UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS

UNITED STATES OF AMERICA

Plaintiff

v.

MOUNT SINAI MEDICAL CENTER

Defendant.

07CV6183
JUDGE ZAGEL
MAG. JUDGE KEYS

Ancillary to an action pending in the United States District Court for the Southern District of Florida – No. 02-22715

JH

MOTION OF SUBPOENA RESPONDENT DAVID C. LEACH, MD TO STAY SUBPOENA FOR DEPOSITION, OR ALTERNATIVELY, TO QUASH SUBPOENA

Subpoena Respondent David C. Leach, MD moves this Court to stay a subpoena commanding his appearance at a deposition on November 13, 2007, pending the resolution of his motion for a protective order filed contemporaneously in the United States District Court for the Southern District of Florida in the matter to which the subpoena is ancillary. In the alternative, Dr. Leach moves this Court to quash the subpoena pursuant to Fed. R. Civ. P. 45(c)(3). In support of this motion, Dr. Leach states as follows:

1. David Leach, MD is a respondent to a subpoena issued by this Court, but ancillary to an action pending in the United States District Court for the Southern District of Florida ("Florida case"). The subpoena commands Dr. Leach to appear for deposition on November 13, 2007 in Chicago, Illinois. A copy of the subpoena is attached hereto as Exhibit A.

2. Plaintiff served Dr. Leach with the subpoena on October 19, 2007.

3. Contemporaneously with the filing of this motion, Dr. Leach is filing a motion for a protective order pursuant to Fed. R. Civ. P. 26(c) with the United States District Court for the Southern District of Florida asking that the court prohibit plaintiff United States from enforcing

the subpoena and ordering that his deposition not be had. A copy of the motion for protective order and its accompanying memorandum are attached hereto as Exhibits B and C.

4. Dr. Leach moves to stay the subpoena pending resolution of the motion for protective order by the United States District Court for the Southern District of Florida. The United States, which is the plaintiff in the underlying action in Florida, and which issued the subpoena from this Court, does not object to the motion for a stay, although it opposes the motion to quash and the motion for a protective order.

5. In the alternative, if this Court will not stay the subpoena pending resolution of the motion for a protective order, Dr. Leach moves this Court to quash the subpoena pursuant to Fed. R. Civ. P. 45(c)(3). A memorandum in support of the alternative motion to stay is filed with this motion and incorporated herein.

6. Fed. R. Civ. P. 45(c)(3)(A) authorizes a subpoena issuing court to quash or modify its subpoena. Fed. R. Civ. P. 26(c) allows either the court in which the underlying action is pending, or the court where a deposition subpoena was issued, to issue a protective order.

7. In the Seventh Circuit, transfer to another District Court of a Rule 45(c) motion to quash or compel is not appropriate. *See, In re Orthopedic Bone Screw Products Liability Litigation*, 79 F.3d 46, 48 (7th Cir. 1996). However, it is appropriate in the Seventh Circuit for a District Court to stay a subpoena to allow the court in which the litigation is pending to rule on a Rule 26(c) motion for a protective order, and to defer to that ruling. *See, In re Orthopedic Bone Screw Products Liability Litigation*, at p. 48; *Griffith v. United States*, 2007 U.S. Dist. LEXIS 47869 (N.D. Ill. 2007), citing *Kearney v. Jandernoa*, 172 F.R.D. 381, 383 (N.D. Ill. 1997); *see*, generally, *In re Sealed Case*, 141 F. 3d 337, 340-42 (D.C. Cir. 1998).

8. Here, the underlying action is brought in Florida by the federal government

against a Florida hospital to recover refunds made by the Internal Revenue Service for FICA taxes paid and withheld by the hospital for payments made to resident physicians.

9. There are at least seven other lawsuits between plaintiff United States and various hospitals currently pending in federal District Courts around the country involving the same overall issue.

10. On April 20, 2007, Dr. Leach was deposed in one of the other seven FICA/resident physician cases, per subpoena by the hospital that is a party in that action ("Ohio case"). The transcript of the deposition is attached hereto as Exhibit D.

11. It is expected that a deposition of Dr. Leach by plaintiff United States in the Florida case would cover the same subject matter as the deposition already taken in the Ohio case.

12. The deposition would be unduly burdensome to Dr. Leach, as it would be duplicative of his earlier deposition taken in a similar action, and during which the plaintiff in this action questioned him extensively.

13. Dr. Leach should not be subject to being subpoenaed for duplicative depositions, whether or not he testifies at a particular trial.

WHEREFORE, Subpoena Respondent David C. Leach, MD respectfully requests that this Court enter an Order staying the subpoena pending the resolution of his motion for a protective order filed contemporaneously with the trial court in the underlying action, the United States District Court for the Southern District of Florida. Alternatively, Dr. Leach respectfully requests that this Court enter an order quashing the subpoena pursuant to Fed. R. Civ. P. 45(c)(3).

Dated: November 1, 2007

Respectfully submitted,

Douglas R. Carlson (0391948)
Nancy F. Afrasiabi (06285608)
WILDMAN, HARROLD, ALLEN & DIXON, LLP
225 W. Wacker Drive
Chicago, Illinois 60606
(312) 201-2000

Attorneys for Subpoena Respondent David C. Leach, MD

CERTIFICATE OF SERVICE

The undersigned certifies that on November 1, 2997, a true and correct copy of the foregoing **Motion of Subpoena Respondent David C. Leach, M.D. to Stay Subpoena for Deposition, or Alternatively, to Quash Subpoena and Memorandum in Support of Alternative Motion of Subpoena Respondent David C. Leach, M.D. to Quash Subpoena,** was electronically filed with the Clerk of the court for the Northern District of Illinois. Notice of this filing will be sent to the following parties via electronic mail:

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brian.r.harris@usdoj.gov

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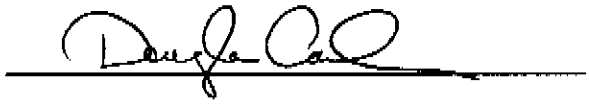

AO88 (Rev. 12/06) Subpoena in a Civil Case

Issued by the

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF ILLINOIS

UNITED STATES OF AMERICA

V.

MOUNT SINAI MEDICAL CENTER

SUBPOENA IN A CIVIL CASE

Case Number:[1] 02-22715 (S. D. Florida)

TO: David Leach
c/o Doug Carlson
Chicago, Illinois

☐ YOU ARE COMMANDED to appear in the United States District court at the place, date, and time specified below to testify in the above case.

PLACE OF TESTIMONY	COURTROOM
	DATE AND TIME

☑ YOU ARE COMMANDED to appear at the place, date, and time specified below to testify at the taking of a deposition in the above case.

PLACE OF DEPOSITION	DATE AND TIME
Wildman, Harrold, Allen & Dixon 225 West Wacker Dr., Chicago, Illinois	11/13/2007 9:30 am

☐ YOU ARE COMMANDED to produce and permit inspection and copying of the following documents or objects at the place, date, and time specified below (list documents or objects):

PLACE	DATE AND TIME

☐ YOU ARE COMMANDED to permit inspection of the following premises at the date and time specified below.

PREMISES	DATE AND TIME

Any organization not a party to this suit that is subpoenaed for the taking of a deposition shall designate one or more officers, directors, or managing agents, or other persons who consent to testify on its behalf, and may set forth, for each person designated, the matters on which the person will testify. Federal Rules of Civil Procedure, 30(b)(6).

ISSUING OFFICER'S SIGNATURE AND TITLE (INDICATE IF ATTORNEY FOR PLAINTIFF OR DEFENDANT)	DATE
John M. Bilheimer, Atty. for Plaintiff	10/19/2007

ISSUING OFFICER'S NAME, ADDRESS AND PHONE NUMBER

John M. Bilheimer, P.O. Box 14198, Ben Franklin Sta. Washington, DC 20044 (202) 514-6070

(See Rule 45, Federal Rules of Civil Procedure, Subdivisions (c), (d), and (e), on next page)

[1] If action is pending in district other than district of issuance, state district under case number.

Exhibit "A"

[redacted]

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
Miami Division

UNITED STATES OF AMERICA Plaintiff v. MOUNT SINAI MEDICAL CENTER Defendant.	CIVIL ACTION No. 02-22715

MOTION OF SUBPOENA RESPONDENT DAVID C. LEACH, MD FOR PROTECTIVE ORDER

Subpoena Respondent David C. Leach, MD moves this Court for a protective order, pursuant to Fed. R. Civ. P. 26(c), prohibiting plaintiff United States from enforcing a subpoena commanding his appearance for deposition on November 13, 2007. In support of this motion, Dr. Leach states as follows:

1. David C. Leach, MD is a non-party to this action. He is a respondent to a subpoena issued by the United States District Court for the Northern District of Illinois. The subpoena commands Dr. Leach to appear for deposition on November 13, 2007. A copy of the subpoena is attached hereto as Exhibit A.

2. Plaintiff served Dr. Leach with the subpoena on October 19, 2007.

3. Contemporaneously with the filing of this motion, Dr. Leach is filing a motion in the United States District Court for the Northern District of Illinois to stay the subpoena pending this Court's resolution of this motion for a protective order, or in the alternative, to quash the subpoena pursuant to Fed. R. Civ. P. 45(c)(3). A copy of the motion to stay or quash (without exhibits) and its accompanying memorandum are attached hereto as Exhibits B and C.

Exhibit "B"

[redacted]

4. The United States, which issued the subpoena from the Northern District of Illinois, does not object to the motion for a stay, although it opposes the motion to quash and the motion for a protective order.

5. Dr. Leach seeks a protective order from this Court pursuant to Fed. R. Civ. R. 26(c) prohibiting the enforcement of the subpoena. A District Court may stay a proceeding and allow filing of a motion for a protective order in the district in which litigation is pending and defer to the ruling of that court. *Clausnitzer v. Federal Express Corp.*, 2007 U.S. Dist. LEXIS 61699 (N.D. Ga. 2007).

6. The underlying action is brought by the federal government against a Florida hospital to recover funds made by the Internal Revenue Service for FICA taxes paid and withheld by the hospital for payments made to resident physicians, and it is currently pending before this Court ("Florida case").

7. There are at least seven other lawsuits between plaintiff United States and various hospitals currently pending in federal District Courts around the country involving the same overall issue.

8. On April 20, 2007, Dr. Leach was deposed in one of the other seven FICA/resident physician cases, per subpoena by the hospital that is a party in that action ("Ohio case"). A transcript of the deposition is attached hereto as Exhibit D.

9. It is expected that a deposition of Dr. Leach by plaintiff United States in the Florida case would cover the same subject matter as the deposition already taken in the Ohio case.

10. The deposition would be unduly burdensome to Dr. Leach, as it would be duplicative of his earlier deposition taken in a similar action, and during which the

plaintiff in this action questioned him extensively.

11. Dr. Leach should not be subjected to being subpoenaed for duplicative depositions, whether or not he testifies at a particular trial.

12. A copy of a memorandum in support of this Motion is attached hereto and incorporated herein.

WHEREFORE, Subpoena Respondent, David C. Leach, respectfully requests that this Court enter a protective order prohibiting plaintiff United States from enforcing a subpoena commanding his appearance for deposition on November 13, 2007, ordering that this deposition not occur, and ordering such other relief as this Court deems equitable and just.

Dated: November 1, 2007

Respectfully submitted,

Douglas R. Carlson (0391948 - Illinois)
Nancy F. Afrasiabi (06285608 – Illinois)
WILDMAN, HARROLD, ALLEN & DIXON, LLP
225 W. Wacker Drive
Chicago, Illinois 60606
(312) 201-2000

Attorneys for Subpoena Respondent David C. Leach, MD

CERTIFICATE OF SERVICE

The undersigned certifies that on November 2, 2997, a true and correct copy of the **foregoing Motion of Subpoena Respondent David C. Leach, M.D. for Protective Order and Memorandum in Support of Motion of Subpoena Respondent David C. Leach, MD for Protective Order**, was filed with the Clerk of the Court for the Southern District of Florida – Miami Division. Notice of this filing will be sent to the following parties via electronic mail:

Brian R. Harris
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IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
Miami Division

UNITED STATES OF AMERICA Plaintiff v. MOUNT SINAI MEDICAL CENTER Defendant.	CIVIL ACTION No. 02-22715

MEMORANDUM IN SUPPORT OF MOTION
OF SUBPOENA RESPONDENT DAVID C. LEACH, MD FOR PROTECTIVE ORDER

Subpoena Respondent David C. Leach, MD submits this memorandum in support of his motion for a protective order prohibiting plaintiff United States from taking his deposition per subpoena on November 13, 2007 in Chicago, Illinois.

BACKGROUND

Dr. Leach was served with a subpoena from the United States District Court for the Northern District of Illinois on October 19, 2007,[1] which subpoena is attached to the motion for a protective order as Exhibit A. The deposition would be unduly burdensome to Dr. Leach, as it would be duplicative of his earlier deposition taken in a similar action, and during which the plaintiff in this action questioned him extensively. This Court should order that the plaintiff not take the deposition of Dr. Leach per Fed. R. Civ. P. 26(c).[2]

[1] The subpoena was served on counsel for Dr. Leach, per agreement with counsel for plaintiff. On October 30, 2007, per Fed. R. Civ. P. 26(c), counsel for subpoena respondent and for plaintiff United States conferred in good faith by telephone in an attempt to resolve this discovery dispute, and the dispute has not been resolved.

[2] Fed. R. Civ. P. 26(c) states, in part,

Exhibit "C"

[redacted]

Concurrently with the filing of this motion, Dr. Leach is filing a motion in the United States District Court for the Northern District of Illinois to stay the subpoena pending this Court's resolution of this motion for a protective order, or in the alternative, to quash the subpoena pursuant to Federal Rule of Civil Procedure 45(c)(3). A copy of the motion to stay (without exhibits) and memorandum in support are attached to the motion for a protective order as Exhibits B and C. The United States does not object to the motion for a stay in the Northern District of Illinois, although it opposes the motion to quash and this motion for a protective order.

This action is brought by the federal government against a Florida hospital to recover refunds made by the Internal Revenue Service for FICA taxes paid and withheld by the hospital for payments made to resident physicians. There are at least seven other lawsuits[3] between plaintiff United States and various hospitals currently pending in federal District Courts around the country involving the same overall issue.

> Upon motion by a party or by the person from whom discovery is sought, accompanied by a certification that the movant has in good faith conferred or attempted to confer with other affected parties in an effort to resolve the dispute without court action, and for good cause shown, the court in which the action is pending or alternatively, on matters relating to a deposition, the court in the district where the deposition is to be taken may make any order which justice requires to protect a party or person from annoyance, embarrassment, oppression, or undue burden or expense, including one or more of the following:
>
> (1) that the disclosure or discovery not be had;...

[3] *United States v. University Hospital, Inc.*, No. 1:05-CV-445 (S.D. Ohio)(currently pending); *Center for Family Medicine v. United States*, No. 4:05-4049 (D.S.D) (currently pending); *United States v. Partners Healthcare System, Inc.*, No. 1:05-cv-11576 (D. Mass.) (currently pending); *University of Chicago Hospitals v. United States*, No. 05-C5120 (N.D. Ill.) (government's motion for summary judgment denied; matter on appeal); *Albany Medical Center v. United States*, No. 04-CV-1399 (W.D.N.Y.) (government's motion for summary judgment granted; matter on appeal); *United States v. Memorial Sloan-Kettering Cancer Center*, No. 1:06-cv-00026 (S.D.N.Y.) (government's motion for summary judgment granted; matter on appeal); *United States v. Detroit Medical Center*, No. 2:05-cv-71722 (E.D. Mich.) (government's motion for summary judgment granted; matter on appeal).

The subpoena respondent is the Executive Director of the Accreditation Council for Graduate Medical Education (ACGME), which accredits the 8,000 plus programs in graduate medical education (residency programs) in the United States, and which is located in Chicago, Illinois. Dr. Leach was approached by counsel for the hospital in this action for deposition or trial testimony. He agreed to appear live at trial in Miami, and the hospital notified the government that Dr. Leach has agreed to appear at the trial of the Florida action. In response to the notification, the plaintiff subpoenaed Dr. Leach for his deposition. Dr. Leach has not agreed to be a paid expert witness for the hospital; he expects to be reimbursed by the hospital only for reasonable travel, accommodation and meals relating to his appearance at trial.

On April 20, 2007, Dr. Leach was deposed in one of the other seven FICA/resident physician cases,[4] per subpoena by the hospital that is a party in that action.[5] The deposition consumed a morning and an afternoon. The transcript is 301 pages without exhibits, including hospital questioning (pp. 7-106; 288-295) and federal government questioning (pp. 106-288; 295-301). The vast bulk of the questioning of Dr. Leach was about the status of resident physicians as students.[6] His testimony addressed residency programs generally, as opposed to

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[4] *United States v. University Hospital, Inc.*, No. 1:05-CV-445, United States District Court for the Southern District of Ohio. For a description of this case, *see*, *United States v. University Hospital, Inc.*, 2006 WL 212981 (S.D. Ohio 2006).

[5] Dr. Leach had previously been subpoenaed for deposition in the *Albany Medical Center* case (see footnote 3), but the deposition did not go forward, as the government was granted summary judgment the day before the deposition was to proceed.

[6] For example,

> Q (by counsel for the United States). Did I hear you correctly to say that, as far as you are concerned, your opinion is that there is no component to the GME other than education? There is nothing else?
> A. Correct.
> Q. Okay.
> A. It includes direct contact with patients. It includes didactic experiences.

the residency programs of the hospital in the Ohio lawsuit. He testified that the ACGME had no opinion as to whether residency program payment to resident physicians should or should not be subject to FICA tax.[7]

It is expected that a deposition of Dr. Leach by plaintiff United States in the Florida case would cover the same subject matter as the deposition already taken in the Ohio case.

ARGUMENT

I. A SECOND AND DUPLICATIVE DEPOSITION WOULD BE UNDULY BURDENSOME TO DR. LEACH

Dr. Leach is a third party witness in this FICA/resident physician case who has already been deposed by the United States in the Ohio FICA/resident physician case. A second and duplicative deposition would constitute an "undue burden" on him.

The deposition of Dr. Leach in the Ohio case was exhaustive. The hospital examined Dr. Leach on direct and redirect (Exhibit D, T. 7-106; 288-295), and the government examined him on cross and recross (Exhibit D, T. 106-188; 295-301). As a non-resident of Ohio, Dr. Leach cannot be subpoenaed by either party to appear at trial in Ohio. As neither party knew at the deposition whether Dr. Leach would appear live at trial,[8] he was questioned to cover both contingencies, i.e., appearance at trial or not. In the Florida action, the plaintiff has been informed that Dr. Leach will appear live at trial. The Ohio deposition should serve at trial in Florida in every way that the Ohio deposition should serve at trial in Ohio.

But it is a consuming experience to achieve the skills necessary to practice independently.
Exhibit D, T. 179-180.

[7] *See*, Exhibit D, T. 167-169.

[8] *See*, Exhibit D, T. 111-112.

There do not appear to be any substantive areas of questioning Dr. Leach that are different as between the Ohio and Florida actions, and it would be unduly burdensome to Dr. Leach to subject him to questioning twice in the same subject matter areas. If there are any subject matter areas of questioning Dr. Leach that are different as between the Ohio and Florida actions, it would be incumbent on plaintiff United States to narrow the subpoena to make clear that there will be no questioning in the same subject matter areas as the Ohio deposition, and thereby avoid imposing on Dr. Leach the undue burden of a duplicative deposition. This would be consistent with Fed. R. Civ. P. 45(c)(1), which states in part, "A party or an attorney responsible for the issuance and service of a subpoena shall take reasonable steps to avoid imposing undue burden or expense on a person subject to that subpoena."

This would also be consistent with the requirements under the Federal Rules of Civil Procedure for taking the deposition of the same person twice in the same case. To take a deposition of a person who has already been deposed in the same case, Fed. R. Civ. P. 30(a)(2) provides that a party to a lawsuit must obtain leave of court "which shall be granted to the extent consistent with Rule 26(b)(2)." Fed. R. Civ. P. 26(b)(2)(C) provides that a court shall limit discovery if it determines that, among other reasons, "the discovery sought is unreasonably cumulative or duplicative, or is obtainable from some source that is more convenient, less burdensome, or less expensive" or "the burden or expense of the proposed discovery outweighs its likely benefit..."[9]

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[9] In actions in which a second deposition of the same witness was requested, courts that have allowed the second deposition have limited the subject matter to those areas not covered in the first deposition. *See Tramm v. Porter Memorial Hospital*, 1989 U.S. Dist. LEXIS 16794 at **5 (N.D. Ind. 1989) ("There is no logical reason why the defendants' new attorney should duplicate the same material covered in the first deposition. Therefore, the second deposition must be limited to those areas not covered in the first deposition."); *see also Perry v. Kelly-Springfield Tire Co., Inc.*, 117 F.R.D. 425, 426 (N.D. Ind. 1987); *Christy v. Pennsylvania Turnpike*

The discovery sought in the Florida action, the deposition of Dr. Leach, "is obtainable from some source that is more convenient, less burdensome, or less expensive," i.e., it is obtainable in the transcript of the Ohio deposition. In addition, "the burden or expense of the proposed discovery outweighs its likely benefit." A second deposition would be burdensome to Dr. Leach with no benefit to plaintiff United States.

II. IT WOULD BE UNDULY BURDENSOME TO OPEN THE DOOR TO DEPOSITIONS OF DR. LEACH IN AS MANY AS SIX OTHER PENDING CASES

As stated above, the Ohio and Florida actions are two of eight lawsuits pending around the country between plaintiff United States and hospitals over the same issue.[10] One party or another may or may not want Dr. Leach to testify at trial in one or more of the other six lawsuits.[11] Dr. Leach may or may not wish to agree to testify at trial in one or more of these additional lawsuits. The parties may or may not want to depose Dr. Leach in one or more of these lawsuits.

Commission, 160 F.R.D. 51, 53 (E.D. Pa. 1995); *Collins v. International Dairy Queen*, 189 F.R.D. 496 (M.D. Ga. 1999).

[10] Each case is unique as to the identity and nature of the defendant institutions and their residency programs, as well as the tax years at issue. In his Ohio deposition, Dr. Leach testified relating to resident physicians and residency programs generally, rather than to particular residency programs (*see*, for example, Exhibit D, T. 136-137; 204-205; 277), with almost no substantive mention of the plaintiff University Hospital. *See*, Exhibit D, T. 42; 136-137 (government question not referring to University Hospital); 141; 152; 181-182 (Dr. Leach has not been to University Hospital); 204-205 (government question general - not referring to University Hospital in particular); 277 (government question general - not referring to University Hospital in particular). As to time frame, he testified to the history of GME from colonial America through the present (Exhibit D, T. 20-32), to GME generally from 1997 through 2004 (Exhibit D, T. 32; 74; 92), and to many GME related occurrences through 2006 (throughout the deposition).

[11] An alternative to live trial testimony in cases other than the Florida and Ohio cases might be offering the Ohio deposition under Federal Rule of Evidence 804(b)(1).

To allow plaintiff to take Dr. Leach's deposition in the Florida action, when plaintiff has already deposed him at length in another FICA/resident physician lawsuit, would open the door to deposing Dr. Leach as many as six more times, all covering the same ground. To place this kind of undue burden on a non-party witness would be unduly burdensome to the witness, without benefit to plaintiff.

Dr. Leach should not be subject to being subpoenaed for duplicative depositions, whether or not he testifies at a particular trial. In addition, he should not have to weigh in the burden of a duplicative deposition as he decides whether or not to testify at a particular trial.

CONCLUSION

The status of resident physicians as students appears to be relevant to the construction of FICA. Given his background, Dr. Leach has information relating to this status. He has not agreed to be a paid expert witness. He gave his subpoena deposition testimony without pay in the Ohio action so as not to give the impression of bias for financial reasons.[12] He would like to do the same at trial in the Florida action. He should not have to be subjected to a deposition in the Florida action covering the same subject matter areas as covered by the Florida plaintiff in the Ohio deposition.

The motion for protective order should be granted.

Dated: November 1, 2007

Respectfully submitted,

Douglas R. Carlson (0391948 - Illinois)
Nancy F. Afrasiabi (06285608 – Illinois)
WILDMAN, HARROLD, ALLEN & DIXON, LLP
225 W. Wacker Drive
Chicago, Illinois 60606
(312) 201-2000
Attorneys for Subpoena Respondent David C. Leach, MD

[12] *See*, Exhibit D, T. 105-106.

IN THE UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION
UNITED STATES OF AMERICA,)
Plaintiff,)
vs.) No. 1:05-CV-445
UNIVERSITY HOSPITAL, INC.)
Defendant.)

The deposition of DAVID C. LEACH, M.D., called for examination, taken pursuant to the Federal Rules of Civil Procedure of the United States District Courts pertaining to the taking of depositions, taken before JENNIFER L. BERNIER, CSR No. 84-4190, a Notary Public within and for the County of Cook, State of Illinois, and a Certified Shorthand Reporter of said state, at Suite 4400, One North Wacker Drive, Chicago, Illinois, on the 20th day of April, A.D. 2007, at 10:09 a.m.

PRESENT:
U.S. DEPARTMENT OF JUSTICE,
(PO Box 55,
Washington, DC 20044,
202-307-6553), by:
MR. STEPHEN T. LYONS,
stephen.t.lyons@usdoj.gov,
MS. ELIZABETH LAN DAVIS,
elizabeth.lan@usdoj.gov,
MS. WENDY J. KISCH,
wendy.j.kisch@usdoj.gov,
appeared on behalf of the Plaintiff;
BAKER & HOSTETLER, LLP,
(312 Walnut Street, Suite 3200,
Cincinnati, Ohio 45202-4074,
513-929-3416), by:
MR. TED T. MARTIN,
tmartin@bakerlaw.com,
appeared on behalf of the Defendant.

PRESENT (CONT'D):
WILDMAN, HARROLD, ALLEN & DIXON, LLP,
(225 West Wacker Drive, Suite 3000,
Chicago, Illinois 60606,
312-201-2643), by:
MR. DOUG R. CARLSON,
carlson@wildmanharrold.com,
appeared on behalf of the Deponent.

ALSO PRESENT:
MR. THOMAS C. GENTILE, JR., MSA.

REPORTED BY: JENNIFER L. BERNIER, C.S.R.,
CERTIFICATE NO. 84-4190

(WHEREUPON, the witness was duly sworn.)

MR. LYONS: Mr. Martin, just before we get started here, I have a suggestion. And that would be that we reserve all of our objections, except any privileges, until the time of the trial.

It will make things go a lot quicker. That's for sure.

MR. MARTIN: No. I think that, if you have objections, then I wish you would state them other than pursuant to the rules.

MR. LYONS: Yeah. And the reason I bring it up is, because of the nature of the opinion testimony problems that we're going to have in this case, I'm probably going to have to object to every question.

MR. MARTIN: Well, then we can talk about that as they come up. And maybe we can have a continuing objection.

MR. LYONS: I don't do continuing objections.

Okay. Okay. We'll do it that way then. That's fine.

MR. MARTIN: Mr. Lyons, isn't the only objection you can make at a deposition an objection

Exhibit "D"

Page 5

to form?
MR. LYONS: No.
MR. MARTIN: Well, let's just proceed. Let's see how it works. We certainly don't want to delay the witness, and we'll take it as it comes.
MR. LYONS: The reason, Mr. Martin, that I bring this up is, as you know, you have listed Dr. Leach as a person who is going to give opinions without an expert witness report. And there is a real gray area problem there as to what he can and cannot do.
And my concern is, if I don't make objections now, I may waive them. So that's my concern.
But if we could reserve them until we can make a decision on that, I will be willing to do that.
MR. MARTIN: If you want to have an objection on that issue -- that issue alone -- then I'll give you a continuing objection on the issue of whether or not an expert witness report was required of this witness.
MR. LYONS: No. I think that it's got to be either we agree to just save them all or we do them

Page 6

all now.
MR. MARTIN: Well, then make your objections --
MR. LYONS: Okay. That's fine.
MR. MARTIN: -- because I don't want to be sandbagged down the road, frankly.
MR. LYONS: Okay. That's fine. Okay.
MR. MARTIN: I'm surprised that you raised this, because we could have done this deposition before the expert report deadline; but it was postponed at your request.
I mean this deposition could have been done in March; but it was postponed. And it was selected for a date that was convenient for you previously. And yet you requested that the deposition be postponed until April, which we've done.
So let's just proceed. We'll fight that out later. And we don't need to bother this witness with it.

Page 7

DAVID C. LEACH, M.D.,
called as a witness herein, having been first duly sworn, was examined and testified as follows:
EXAMINATION
BY MR. MARTIN:
Q. Would you please state your name.
A. David C. Leach.
Q. Dr. Leach, are you currently employed?
A. I am.
Q. And who are you employed by?
A. The Accreditation Council for Graduate Medical Education, also known as the ACGME.
Q. If you were talking to your neighbor and your neighbor asked you, "Tell me. What does the ACGME do," what would you tell him?
A. I would tell him, "I could tell you, but then I would have to kill you." And that's what I usually say, because it is hard to explain.
Q. Okay.
A. But the Accreditation Council for Graduate Medical Education is a 501(c)(3) not-for-profit corporation.
It is private and independent. And it sets the standards for and accredits the nation's

Page 8

8,000 residency programs that in aggregate house 100,000 residents.
Q. Did you say that sets the standards for graduate medical education?
A. I said, for residency programs and graduate education, Graduate Medical Education is the period of education between medical school -- which is also known as Undergraduate Medical Education -- and independent practice, an area covered by life-long learning or Continuing Medical Education.
Q. I gather that you know something about medical education; is that right?
A. I think so.
Q. Okay. Why don't we do this? I would like to get a sense of what your background is.
And maybe the easiest way to do that is by looking at your curriculum vitae?
MR. MARTIN: And, if we could, mark that as an exhibit.
(WHEREUPON, a certain document was marked Leach Deposition Exhibit No. 1, for identification, as of 04-20-2007.)

Page 9

BY MR. MARTIN:
Q. Dr. Leach, I've handed you a document, which the court reporter has marked as Leach Exhibit 1.
And, first of all, can you tell me what this document is?
A. This is my curriculum vitae.
Q. And does it provide an overview of your background -- your experience, your training?
A. It does.
Q. Can you just kind of sum -- and is this document -- is it accurate?
A. Yes.
Q. Okay. Can you just tell us -- give us an overview -- of kind of what you've done since college in terms of both your education, and your training, and your employment?
A. I've graduated from the University of Toronto, St. Michael's College. And I graduated in 1965.
After that I went to medical school at the University of Rochester School of Medicine and Dentistry, in Rochester, New York. And I graduated in 1969.

Page 10

After that I completed an internship and residency at the Henry Ford Health System in internal medicine. I was the Chief Medical Resident for one year. And then I did an endocrinology fellowship for two years.
I had some supplemental training at the Children's Hospital of Pittsburgh. In 1975 I had joined the staff of the Henry Ford Hospital as an endocrinologist.
One of my responsibilities was to teach the junior medical students from the University of Michigan. Each year the University of Michigan would send 36 students to Henry Ford. And I was charged with their -- I was monitoring and direct teaching, but also monitoring the teaching they got on various rotations. In that capacity, I was an Assistant Dean at the University of Michigan.
In 1984 I became a program director of the transitional year residency program and also what we would now call a DIO, or a designated institutional official -- the one charged with the responsibility of all of the residency programs at Henry Ford.
At that time we had about 800 residents,

Page 11

and we had about 60 residency programs. And I was administratively responsible for all of that, as well as the identified official for purposes of ACGME.
In 1997 I joined the ACGME as its Executive Director. And I have been here for the past ten years.
Q. Would it be correct to say that the executive director of the ACGME functions very similar to the CEO of an organization?
MR. LYONS: Objection. Form. Misleading.
BY THE WITNESS:
A. The title has recently been changed to CEO; and so I think the answer to the question is, yes.
BY MR. MARTIN:
Q. Okay. We have previously marked in this case another exhibit. And I'm going to hand it to you. It's a big green book. And it's marked as Gentile Exhibit 2.
Do you recognize this book?
A. I do.
Q. And can you tell me what it is?
A. This book is published by the American

Page 12

Medical Association. It's not a direct product of the ACGME; but it does have all of the institutional and program requirements created by the ACGME.
In addition, it has a listing of the various residency programs by specialty in the country; and it also has some other general information about Graduate Medical Education.
Q. Is this a book that is sometimes referred to as, "The Green Book"?
A. It is.
Q. Could I ask you to turn to page 31 of, "The Green Book"?
MR. LYONS: What's the Bates Number?
MR. MARTIN: The Bates Number is 6413.
BY MR. MARTIN:
Q. And have you read this section before of, "The Green Book"?
A. I have.
Q. And in this section of, "The Green Book," is this -- it's called, "The Essentials of Accredited Residencies in Graduate Medical Education: Institutional Program Requirements."
Do you see that?
A. Yes.

Page 13

Q. And I notice that here the ACGME talks about the education of physicians. Do you see that?
A. I do.
Q. And it talks about the education of physicians as occurring in three stages?
A. Correct.
Q. From the perspective of the ACGME, what are those three phases -- as defined by the ACGME -- of the education for physicians?
A. Undergraduate Medical Education, Graduate Medical Education, and Continuing Medical Education.
Q. I would like to talk to you a little bit about each of those. And sometimes, to get a handle on it, it's nice to look at it in terms of what it means to an individual person.
Maybe we can use your background and talk, then, about what are the three phases and how that relates to your background and training.
Sometimes I might try to give you an overview of where we're going so it may be a little bit clearer. So that's kind of one of my signposts. So the next few questions would relate to that?
You mentioned there are three phases according to the ACGME. And the first phase was

Page 14

Undergraduate Medical Education?
A. Yes.
MR. LYONS: I'm going to object. You keep referring to the ACGME; and, yet, he's testified that this is an American Medical Association document.
BY MR. MARTIN:
Q. Are, "The Essentials of Accredited Residencies in Graduate Medical Education: Institutional Program Requirements," prepared, derived, from the ACGME?
A. Yes. I think I've testified that this green book is published by the American Medical Association; and it includes the requirements developed by the ACGME. These are ACGME requirements.
Q. Okay. So the ACGME requirements for the -- is this kind of sometimes referred to as, "The Essentials"?
A. Yes.
Q. Okay. I'm just trying to get the terminology.
And in there -- the ACGME's Essentials -- there is a discussion of the three phases of medical

Page 15

education. The first phase is, "Undergraduate Medical Education."
What is meant by, "Undergraduate Medical Education"?
A. This is the education that occurs in medical school. And, typically, it's a four-year educational program. It's a dynamic world, and things are changing.
But, in general, the first two years of medical school consist of learning the sciences -- anatomy, physiology, biochemistry, histology, pathology, and so on. In the last two years, medical students begin to get exposed to clinical cases.
The Undergraduate Medical Education Phase is concluded with the awarding of the M.D. degree.
Q. Go ahead.
A. The Graduate Medical Education Phase begins with an organized structured residency program. I would define Graduate Medical Education as an organized educational program accredited by ACGME; i.e., it meets our standards.
The purpose of Graduate Medical Education is to prepare the student for independent practice.

Page 16

And it takes the sort of rules and fundamentals learned in medical school and applies those rules in increasingly complex clinical cases so that residents may learn judgment and the practical skills of becoming a doctor.
I would say that Graduate Medical Education varies in duration. There is one minor aberration. And that is the transitional year is a one-year program that serves, fundamentally, two purposes:
One, to enable students to discern what they want to become so they will experience different rotations, if they haven't already decided that in medical school. The other purpose is, it is sometimes used as a prerequisite year for further training in the various specialties.
But other than that aberration, the duration of Graduate Medical Education is from three to ten years. It is concluded by graduation from the program with a statement from the program director that the individual is competent and now eligible to take their certification exam, at which point the American Board of Medical Specialties, and its particular member boards, will receive the

Page 17

graduate and offer an examination after reviewing all of their credentials. And then it is possible to become a board certified internist, surgeon, pediatrician, family physician, whatever.

And then that begins the third phase of Continuing Medical Education, which is really a period of life-long learning. That is in a very dynamic change right now, including things like maintenance of certification. The individual certifying boards will track the experiences of practicing physicians for the rest of their life in four areas:

One, their maintenance of licensure and good ethical standing by their respective state medical board.

Two, their Continuing Medical Education experiences -- formal didactic experiences. And, recently, it's required that that be relevant to the particular specialty that they're practicing.

Third, some analysis of ones practice. So, for example, the American Board of Internal Medicine actually surveys patients of the particular doctor and samples that. They also look at the outcomes of, for example, diabetic patients in the practice

Page 18

and so on. So an analysis of the practice and a demonstration of the ability to improve ones practice is the third element of maintenance of certification.

And the fourth element is an examination that must be taken every ten years.

And that continues through to maintain ones certification. You do that through retirement or death. It goes on forever.

Q. Well, on the first phase, Undergraduate Medical Education -- sometimes we use the phrase, "undergraduate school," to mean the years right after college.

Is that how that term is meant here?

A. It is confusing. Usually, "undergraduate," means college and graduate school. You might get a Ph.D. or something.

And in medicine it is thought that college is preparatory to entrance into the undergraduate period. Medical education is so unique. It does not use the usual language of the rest of the educational world.

Q. So if the first phase is Undergraduate Medical Education, for you that would have been your

Page 19

training at the University of Rochester School of Medicine and Dentistry?

A. Correct.

Q. And then, when you graduated from that program, you received your M.D. degree?

A. Correct.

Q. And then, after you received your M.D. degree, you began entering your second phase of medical education; is that right?

A. Correct. Correct.

Q. And that would be the residency years and fellowship years?

A. Correct.

Q. Now, we're using some terms here that a lot of people -- if you're not in the medical world -- may not know. For example, a resident and what it means to be a fellow.

Can you tell us what do you mean by a resident? And what's a fellow? And what's an intern?

A. You're quite right. The language is confusing. And maybe it would be best to give some historical perspective of how this evolved.

And the three words that can be confusing

Page 20

are house pupil, intern, and resident. And to explain that story, I may go back even farther to Colonial America where the spirit of democracy was so strong there was -- any attempt to regulate a special class of citizen was issued by society.

So there were no licensing. Physicians weren't licensed. There was no board certification process. Medical schools were extremely rudimentary, usually proprietary. And this could only be tolerated because not much was known in medicine. And the scientific advances had not occurred.

In the early 1800s -- I think around 1830 -- the idea of a house pupil emerged. And I may be wrong; but I think that Cincinnati Hospital was the first place, in the United States, to have house pupils. House pupils -- before the Civil War and after the Civil War -- had a different meaning.

Before the Civil War, a house pupil was someone who spent one year of practical training, before they entered medical school, just to see if they really wanted to take care of sick people. And they did a lot of the tasks of nurses and of others just caring for the sick. If they performed well

Page 21

and if they liked it, then they entered medical school.

And medical school in those days was very different. It consisted, typically, of -- first of all, there was a lot of variability. And one of the things that has emerged is a national standard. ACGME has a national standard to dampen the variability in residency. But in those early days, there was a lot of variability in medical school.

But, in general, it consisted of two six-month periods of training -- usually conducted in Latin and usually during the winter months so that farmers could come. And many of the medical students did not have a high school education.

And then they would apprentice themselves to a physician and do menial tasks, quite often -- like grooming the horses and sort of taking care of the daily chores -- that really weren't very relevant to medicine. So that existed in the early 1800s. So you would have this one-year house pupil experience, go to one of these medical schools, and then have an apprenticeship afterwards.

The Civil War exposed that, number one, medicine didn't know anything; and, number two, that

Page 22

medical education was in dire need of reform. More people died of illness and medical malfeasance in the Civil War than died of bullets.

MR. LYONS: Died of what?

BY THE WITNESS:

A. Died of bullets.

And it was all sort of opinion. For example, one opinion at the time, during the Civil War, was that pus was good. And so, if you were a doctor taking care of a patient with an abdominal wound and in the next room was another patient with an abdominal wound, you would pick the pus up and put it in the second patient hoping that the white cells would help that patient heal. Of course, that was exactly the wrong thing to do. It just infected the second patient.

So while this was going on -- in Germany and in France -- scientific studies were conducted that actually compared different interventions and began to build some evidence about what interventions were helpful and what were not. So a body of knowledge emerged with that, now, heavier content to learn to be a doctor.

After the Civil War, the house pupil

Page 23

system -- the house pupil took their one-year experience after medical school; and, instead of grooming horses, it sort of replaced the apprenticeship and was a more formal one-year experience almost always based in the hospital.

That blurred with internship. So the post-Civil War house pupil and the internship became, eventually, synonymous. It was a one-year experience.

At the latter part of the 1800s, the public was so appalled with medical education and the inability of medicine to help people that demands for reform occurred. And the first reforms came out of the University of Michigan, Harvard, the University of Pennsylvania, and later -- in the 1890s -- at Johns Hopkins.

And Johns Hopkins was the first place in the country, in the late '90s, to have what we would call a residency program. And at that time it was structured so that you would do a one-year internship followed by further practical training called a residency. And that was really the end of the house pupil system and the beginning of the internship/residency system.

Page 24

In 1910, again, on the swell of this public demand for reform of medical education, the Carnegie Foundation hired Abraham Flexner. And he surveyed all medical schools in the United States. I think at that time there was something like 162 medical schools.

These were terrible places for the most part. I mean, they were proprietary schools. The faculty would not get paid unless the students graduated. So all students graduated.

They consisted of, in Carnegie's review -- as he went to these so-called medical schools, he would say, "Let me see your laboratories." He writes very vividly in one school they opened a cigar box and showed him three test tubes and said, "This is our laboratory."

So he came out with recommendations -- the Flexner Report, which was published in 1910 -- that described the following recommendations:

That, one, a medical school -- you enter medical school after graduating from college. Medical school must be linked with a university. It should not be a free-standing proprietary. It must have some fundamental capacity in science and

Page 25

research and more than three test tubes in a cigar box. The faculty should not be paid by the students directly, but should be paid by the medical school whether the student passed it or not.

So these reforms were recommended and instituted. And Carnegie categorized medical schools into different sort of grades in the top tier systems. And I think that Hopkins was at the very top, and then others like the University of Michigan and so on.

And then there were a bunch that didn't make the grade so, in that one process, the number of medical schools, in the United States, went from 162, or something, down to 82. It got rid of half of the medical schools.

And that was followed in, I think, 1919 -- maybe, 1918, 19 -- by the AMA's Council on Medical Education publishing Standards for Essentials for Internships. And so it's not an accident that ACGME standards exist in an AMA publication because, historically, the AMA was a big advocate for reform of medical education beginning in the 1870s and -- in 1918 or 19 -- published the first Essentials just for internships.

Page 26

All right. And they specified that this sort of practical experience was needed to practice safe medicine. And there were certain standards that you had to meet. Later on they published the Essentials for residencies. And they would begin in a crude way. But, nonetheless, they would begin to do site visits and have comments about the various residency programs.

In 1949 -- I should say the first certification process occurred around this time in the -- I'm blurring on it. It was around 1917, or something, the American Board of Ophthalmology offered a certificate and said, "You shouldn't be able to take a knife and put it into a person's eye unless you've had a certain amount of practical experience under supervision."

It wasn't enough to pop out of medical school, and pick up a knife, and go operate on someone's eye. So they required that you become board certified in ophthalmology in order to be a recognized ophthalmologist.

Initially, that process consisted of an examination -- review of your training. You had to graduate from medical school. You had to have some

Page 27

just practical experience in a residency/internship. And you had to pass this exam.

By 1936 most of the now well-known specialties had established a board certification exam. It was also noticed that many could not pass those exams and did not meet the standards to be an ophthalmologist, or an internist, or a surgeon, or a pediatrician.

So in 1949 the first residency review committees were created -- initially, surgery and three months later medicine. And they, for the first time, spread beyond the AMA. So the AMA had identified one-third of the appointees, for example, in the case of surgery, and the American Board of surgery another third, and the American College of Surgeons a third-third.

And that constituted the Residency Review Committee For Surgery; likewise, medicine -- AMA, American College of Medicine, American College -- or American Board of Internal Medicine, American College of Physicians.

Those groups of experts developed standards for their specialty and began to do site visits, in greater depth and understanding, and

Page 28

would publish whether a particular surgical residency met their standards or not. And if you didn't meet them, you had to graduate from an accredited surgery program to sit for the certification exam by the American Board of Surgery.

By 1956 most of the now well-established specialties had residency review committees. The residency review committees functioned independently. They each had their own sort of process.

The mechanics were different. So how you did a site visit, how you gathered information, all of that was different. There was also a lack of adequate appeal mechanism. If a program wanted to have a reconsideration of its adverse action, there was nowhere to go except back to the residency review committee.

So in 1972 the Liaison Committee For Graduate Medical Education was established. It was, frankly, very dysfunctional.

There were three layers. There was the Residency Review Committee, the Liaison Committee For Graduate Medical Education, and the Coordinating Committee. The Coordinating Committee had three

things -- the LCME, which did medical schools; the LCGME, which did residency; and the LCCME, which did Continuing Medical Education.

What happened was predictable and embarrassing; and that was that all programs reviewed by the Residency Review Committee were, in turn, reviewed by the LCGME, who were, in turn, reviewed by the Coordinating Committee. It was total chaos. Everybody got three reviews. They differed in their outcome. It was a mess.

So in 1981 the ACGME was established and made a little more independent, and a little less political, and coordinated the efforts of the various residency review committees.

So, now, there are 26 residency review committees, basically, constituted for the specialties, as I've described, for medicine and surgery -- although some differences -- the transitional year review committee, for this one-year program, and an institutional review committee -- which came later -- which sets standards and makes judgments about the sponsoring institution's administrative apparatus to conduct any educational programs.

So ACGME coordinated the efforts of the various review committees in a way that was coherent and predictable to hospitals so that they sort of knew what was going to happen. And the ACGME logo got you into the certification exam, or the medical license, or later on connected you to some Medicare funding in support of Graduate Medical Education.

Of course, the world isn't static while all of this is happening. The body of knowledge building up is tremendous. And because our capacity to know is finite and the capacity to generate new knowledge -- while not infinite -- exceeds our capacity to know it, it was natural to subspecialize and specialize.

So you went from internal medicine training, to internal medicine followed by cardiology training, to internal medicine training followed by cardiology, followed by electrophysiology as you broke down the new knowledge into chunks that a single person could master. That latter category of subspecialties and advanced training became known as fellows.

So that's a long-winded answer to your simple question of the distinction between

internship, residency, and fellows. And I added house pupils just hoping that the historical approach would give some clarification for these confusing terms.

BY MR. MARTIN:

Q. Was there, then, a period of time when the term internship was used as the first year after you graduated from medical school?

A. Yes.

Q. Is that term used today?

A. Casually, but not formally. We now think of a residency as beginning right after medical school.

Q. Has the ACGME formally abandoned the term internship?

A. Yes.

Q. Okay. And that period, in the second phase of medical education -- which you've referred to, I think, as Graduate Medical Education --

A. Yes.

Q. -- is sometimes referred to as GME; is that right?

A. Correct.

Q. Is that, then, broadly defined as the

residency period?

A. Yes.

Q. And are fellows, like, a subset of residents then; or are they --

A. We actually went through a period of time, in the late '90s and early 2000s, where we eliminated the term fellow and called everybody residents.

We've resurrected the term fellow, in the last few years, because the habits were so entrenched and people wanted to let the world know they were in an advanced training program and wanted to be called a fellow. So we use both terms now.

Q. And for the period in this case -- the years at issue are in 1997 through 2004?

A. Yes.

Q. During that period, what do we mean by fellow, and what do we mean by resident? Can you just give me --

A. Yes. A resident is, in one of the core programs, leading to initial certification. A fellow is, in an organized educational program accredited by ACGME, leading to subspecialty certification.

Page 33

Q. Now, you did your residency in internal medicine; is that correct?
A. Correct.
Q. You specialized -- is that the correct term -- in that area?
A. Correct.
Q. First of all, tell me what internal medicine is just so we have some idea? What's that the study of?
A. It is the -- it's everything in the world.
MR. LYONS: Give us the program requirements.
BY THE WITNESS:
A. A practicing internist specializes in, essentially, all human ailments and is particularly interested in diagnosing disease, in managing illness -- as opposed to surgical intervention -- in managing late adolescence and adults -- as opposed to children -- and managing woman, woman who are sick -- but not during pregnancy, or delivery, or for gynecological problems.
So it is a doctor for adults.
BY MR. MARTIN:
Q. So if my personal physician specializes

Page 34

in internal medicine, that's not unusual then?
A. Right. That would be quite common.
Q. And so, then, your initial -- you would have gone through a residency in internal medicine?
A. Correct.
Q. How would a fellow, in the area of internal medicine, differ from someone who has just graduated from a residency program?
A. Well, I was a fellow in endocrinology. I was not a fellow in internal medicine.
Q. So it's a subspecialty then?
A. Correct.
Q. So does everybody who graduates from a residency program in internal medicine go on --
A. No.
Q. -- to a subspecialty program?
A. No. There are many who will complete their training -- their formal organized training at that point -- and become board certified internists. And then they're able to practice independently.
Fellows would want advanced training in one of the subspecialties.
Q. So college, as we know, is four years. Medical school is four years -- I think you've

Page 35

said -- typically?
A. Right.
Q. A residency program in internal medicine -- how long, typically, is that?
A. Three years.
Q. And then, if you do a subspecialty, is it, then, additional years after that?
A. It is.
Q. And with that the number of years depend on the subspecialty that you're in?
A. It does.
Q. Okay.
A. Just to put things in perspective, we accredit 26 core specialties. And we accredit, in total, 120 specialties and subspecialties.
So medicine, pediatrics, family medicine, surgery, pathology, and so on, would be core specialties. And cardiology, gastroenterology, transplant surgery, and so on, would be subspecialties.
Q. When you were describing the history of medical education, or the education of physicians, I think you indicated that there was a period of time when there was really an absence of governmental

Page 36

regulation.
Am I right on that?
A. Correct. And I think that, to some extent, remains true today. We are -- the ACGME -- is the definitive standards that are for Graduate Medical Education. And we are not regulated by the government.
Our work is recognized by the government. And it is recognized through a payment system that supports Graduate Medical Education. In order to get money from the government, you must be accredited by ACGME. If we withdraw accreditation, that money doesn't come any more.
We also have, on my board, a federal observer who sits without vote -- but is free to observe our activities -- and gives us a report at every meeting about various issues of interest that they would like us to hear about. And this is somewhat unusual and, I think, reflects the nub of your question about government regulation and about our roots in democracy.
In most countries, our kind of work is, in fact, done out of the Ministry of Health of the various governments. But here the public and the

Page 37

government have delegated that work, if you will, to the profession.

And so we are the professional standards that are for Graduate Medical Education and are not regulated by the federal government.

Q. So in this second phase of medical education called Graduate Medical Education, there are standards that exist in terms of what those programs --

A. Yes.

Q. -- and institutions must comply with; is that right?

A. Correct.

Q. And what is the role of the ACGME in connection with those standards?

A. The individual residency review committees develop a proposed set of standards. Let me first give you a little skeleton of the structure of the ACGME.

Q. Okay.

A. So there's my board -- 26 members, plus the federal observer. There are the review committees, including the 26 review committees for various specialties and subspecialties, the

Page 38

Transitional Year Review Committee, and the Institutional Review Committee.

And then there are standing committees of the ACGME. The Program Requirements Committee is one of them. There's also Monitoring. And there's Strategic Initiatives and Financing. So the process works as follows:

Program requirements are developed by the relevant Residency Review Committee. They are, at that point, proposed program requirements. Each review committee must do that, at least, every five years. And they're welcome to do it more frequently if the field changes in a way that's substantial enough to require changes in the program requirements.

The proposed requirements are, then, vetted through the entire community. So the announcements go out, and people are invited to look at them from all other specialties -- all of the medical school deans, all of the program directors, the DIOs. The government, the public, anybody, is invited to comment on these proposed program requirements.

Those comments come back. And the

Page 39

Residency Review Committee also must create an impact statement of the requirements -- both financial, and organizational, and any other impacts of the proposed program requirements. So they, then, develop a document of the proposed program requirements in which every concern harvested -- from the public, or other specialties, or anybody -- is addressed by the Residency Review Committee.

And the Impact Statement is clear. And that package -- the Proposed Program Requirements, Comments and Responses, the Impact Statement -- go to ACGME's Program Requirements Committee. The Program Requirements Committee reviews this, hears it in an open session from anybody who wants to comment on it, and then makes a recommendation to my board.

And the board acts to either approve or not approve the program requirements. And so the ACGME uses that mechanism to develop and approve its requirements.

Q. So the ACGME develops standards that measure the -- strike that.

The ACGME develops standards for Graduate Medical Education?

Page 40

A. Yes. And it does it using this mechanism.

Q. And does it have standards for the institutions, or for the programs, or for both?

A. Both.

Q. So let's just talk in very specific terms for one year.

You have a green book in front of you for one year. I think it's 2000 and 2001 -- that 12-month period.

Can you show me where -- and maybe just by pages -- where are the requirements for the institutions?

A. The Institutional Review Committee -- the institutional requirements established, initially, by the Institutional Review Committee and approved by ACGME is on page 34, 35, 36, and 37.

Q. Okay.

A. And you can see, for this particular year -- at the end of it, on page 37 -- the last words are, "ACGME, September 1998."

That is when they were approved by ACGME. And they were made effective the same time, September of 1998.

Page 41

Q. Now, there's a term that's been used in this case before, which is the, "sponsoring institution."
What does that mean to the ACGME?
A. The sponsoring institution is the organization that has ultimate authority and accountability for all of its residency programs.
Q. So the institutional requirements, then, would apply, then, to the sponsoring organization?
A. Correct.
Q. Okay. And then, beyond the institutional requirements, are there also program requirements?
A. There are.
Q. And are those set forth somewhere in this book?
A. Yes. And I think one way of doing this would be to tell you they are set forth from pages 38 to page 374.
Q. And the programs -- for example, would internal medicine be its own program, versus family practice, versus anesthesiology?
A. Yes.
Q. Okay. And would each program, then, have its own requirements or standards?

Page 42

A. Each specialty has its standards. Each program that's going to be accredited must meet those standards.
Q. Oh, I see. The program would be the program at University Hospital?
A. Right.
Q. And then the --
A. So it's an important point, because the standards are national standards. These are not corporate standards. The University Hospital may or may not have their standards.
But to be ACGME accredited, there is a uniform set of standards that all programs -- for example, in internal medicine -- must meet if they're going to be accredited.
Q. So whether your program is in California, New York, or Ohio --
A. Right.
Q. -- in order to be accredited by the ACGME, it would have to, then --
A. Meet the standards.
Q. -- meet these standards?
A. Right.
Q. And how does the ACGME determine whether

Page 43

or not an institution meets the institutional requirements and whether its programs meet the program requirements?
A. They use the following mechanisms: The program or the institution about to be reviewed submits information. And ACGME creates an institutional review document that gathers information relevant to the institutional requirements. And the various residency review committees establish a program information form that gathers information relevant to the program requirements.
So the programs and the institution complete those documents and send them to the relevant review committee -- Institutional or Residency Review Committee. Additional data comes in.
We survey the residents anonymously over the Internet. So there's 100,000 residents in the United States. And we have questions relevant to our standards that we ask individual residents. And their anonymous replies are sent back via the Internet.
And so we have a resident survey that's

Page 44

an additional piece of data. Depending on the specialty, we will have case logs as well. So each year over 6 million cases managed by residents enter our servers.
And so, for example, the surgery review committee requires that residents have between 500 and 1,000 major cases in five years. They also further specify how many cases must be done in the senior or chief resident year.
And so the review committee will see those cases so they can look at and make sure each resident has done 500 or a 1,000 operations before they're turned loose on the public to function independently.
So we have the program information forms, the resident survey, and -- in some, but not all, specialties -- case logs. We also have any correspondence. We have any resident complaints. We have any sort of dynamic data -- like faculty turnover, and so on.
With that we send a site visitor in to do a site visit of the program. The site visitor's function is to verify and clarify that what is said -- on the program information form -- to have

Page 45

existed, in fact, exists. And they use a triangulation process of interviewing residents, interviewing faculty, interviewing the program director, and sometimes the DIOs, sometimes the CEOs, sometimes the dean -- but in all cases, the residents, faculty, and program director.

And they do -- they'll walk around and see that facilities are adequate. And they will clarify and verify the information, from the aforementioned sources, and write a report. So then the Residency Review Committee meets.

Now, the Residency Review Committee -- I should say the ACGME has 120 paid employees and about 300 volunteers. So some of the employees serve to support these various residency review committees. Others are site visitors and so on.

The Residency Review Committee members -- the voting members of the review committee -- are all volunteers. And so they come together as a group of, perhaps, 15 people would be typical -- for example, of surgery -- and will review the program information form, the resident survey, the case log data system -- and by resident and by program. And they have national data so they can see where this

Page 46

program is relevant to all other programs in the country -- and the site visit report.

And then they make a determination, using that data, whether the program is in substantial compliance with the requirements. And then they notify the program of their decision. "You're accredited. We're proposing probation." And there are various categories.

The longest cycle length -- except for a few experiments that we're doing, the longest cycle length is five years. So even if everything is great, we're going to visit you, again, in five years. The average cycle length is about 3.7 years.

So, typically, we'll say, "You're accredited. But we're concerned about this, this, and this. And we'll detail that in citations. And we're going to come back and visit you in three years." Or, if we're very concerned about you, in one or two years.

Or we might say, "We don't think you're in substantial compliance. And we're proposing to put you on probation." Or, in egregious cases, "We're proposing to withdraw accreditation."

The program can, then, ask the review

Page 47

committee to reconsider if they have an adverse action, like a proposed probation. The review committee can reconsider and review the same data and some new data that the program may want to submit for clarification.

And they may sustain their initial tendency to adverse action. The program at that point can appeal to the ACGME. The ACGME has another panel of volunteers for all of the specialties -- each of them expert in their field, but different and independent of the review committee.

The program can physically appear before them and present oral arguments and written materials to the appeals panel. The appeals panel will make a recommendation to the ACGME board. The ACGME board will act. And that is final.

So that's a thumbnail of the process we use.

Q. And was that the same process during the period of '97 through 2004?

A. Yes. The only -- yes, we did. In '97 we did not, yet, have the resident survey. In 2004 we did.

Page 48

Q. Okay. If you look at the green book, on pages 12 through, I think, 17 -- or 11 through 17, does that lay out accurately the accreditation process?

A. Of the time, yes.

Q. At the time?

A. Yes.

Q. And, of course -- and then the green book, for the next year, would set out the process for the following year?

A. Right. Right.

Q. From the perspective of the ACGME, what is the purpose of accreditation?

A. The purpose of accreditation is to discern and publically recognize whether a residency program is in substantial compliance with our standards. And we do that. Several entities rely on our decisions.

And so we do that independently. But having then published it, the federal government, the certifying boards, the licensing boards, the credentialing committees of various hospitals -- and undoubtedly others -- use that decision to determine their subsequent action.

Q. In developing the standards that it applies or sets, what does the ACGME view as the purpose of medical education?
A. The purpose of Graduate Medical Education?
Q. Of Graduate Medical Education, yes.
A. The purpose of Graduate Medical Education is to provide an organized educational program that will lead the physician to appoint that they're able to practice independently.
Q. Is there, from the ACGME's perspective, any relationship between Graduate Medical Education and patient care?
A. Yes.
Q. And what's that relationship?
A. I think that you have to have good patient care to have a good residency program. If the hospital you're working in cannot provide good patient care, you're not really able to teach good habits of patient care.
And so that's our relationship. We do not measure patient care ourselves. We are concerned with Graduate Medical Education. But we use others -- including the Joint Commission on

Accreditation of Hospitals -- to determine whether adequate patient care is being provided.
Q. Is there any relationship, from ACGME's perspective, between Graduate Medical Education and improving patient care?
A. Yes.
Q. And what's that?
A. The ACGME, in February of 1999, endorsed six competencies that all 100,000 residents have to master and all 8,000 programs have to teach and evaluate.
Patient care is one of those six competencies. Practice-based learning and improvement is another. So we expect every resident to learn how to analyze their practice and to improve it.
The other four are medical knowledge, interpersonal communication skills, professionalism, and something called systems-based practice, which is really to sort of diagnose and treat dysfunctional systems in a way analogous to the diagnosis and treatment of disease as medical care has gotten very complex, and the potential for harm is extremely real, and as we have learned, as a

community, the prevalence of medical error. And, for example, the Institute of Medicine feels that most medical error is because of faulty systems rather than individuals.
And a deep understanding of systems -- and their relationships with the quality of patient care, and the ability of the system to improve patient care -- is an important part of the curriculum. So with those competencies, we've broadened the knowledge base.
It's no longer just medical knowledge and patient care. But you actually have to pay attention to these other four things if you're going to be accredited by ACGME.
Q. And those are referred to as the six competencies. Is that the term you used?
A. Correct.
Q. I want to come back to those a little bit later.
If one of the purposes of medical education is to improve patient care -- let's look at it from another perspective. How has the ACGME looked at -- how do physicians, how do doctors, learn to be better doctors?

A. There's only one way of learning that. You can learn all of medical knowledge you can stuff into your brain. You can learn a deep understanding of the rules of medicine.
But in order to become a competent physician, you have to apply those rules in various contexts; i.e., with particular patients. And you have to do it frequently enough and in enough of a disciplined way that you learn the relationship between rules and context.
In other words, a clinical judgment must take into account the attributes of the patient and not just the attributes of the disease. And so you have to see patients and you have to take care of them and make decisions under supervision until you get that relationship right.
If you were to learn how to drive a car and had a rule book of how the car works and the law of the land -- in terms of traffic violations -- but had no experience actually driving a car, and then were exiting in a freeway ramp and didn't know exactly how to downshift or not, or take your foot off the accelerator or not -- you didn't have that sort of feel of how a car actually works under road

Page 53

conditions -- your training wouldn't be adequate in driving a car.

And recognizing and treating the myriad of illnesses that happen to patients is a lot more complex than driving a car. And so, for example, let's say that I have an Aunt Evelyn who I've known and loved all of my life.

And let's say you have a photograph of my Aunt Evelyn. And we're out walking on the streets of Chicago. And two blocks away I say, "That's my Aunt Evelyn." And I know it because of the jaunt of her walk. And that's her favorite hat. And I know that's my Aunt Evelyn.

You have a photograph analogous to a textbook description of a disease. But you've never seen my Aunt Evelyn. So you're looking at the photograph. And we have to be this close, (indicating). And then you say, "That's Aunt Evelyn."

Well, recognizing disease is like that, you get to a point where your intuition tells you what's going on because you've seen the disease so many times. And you need to get -- you don't need to be a master physician. But you need to get to

Page 54

the point that you're beyond just textbook descriptions of disease.

Or, in a surgical case, it's not accidental that the surgeons require that you do 500 to 1,000 operations before you graduate. You would not want a medical school graduate -- who, in some cases, may have never even been in an operating room certainly in the -- I mean, essentially, in all cases, has not done any sort of surgery -- to pop out, and graduate, and say, "Okay. Now, you can take my gallbladder out."

I mean, that would be very dangerous for the public. Really bad things happen to patients unless you are adequately trained to practice independently. So society has put these constraints on licensure, on certification, on credentialing, and has used the ACGME to make sure you get adequate practical experiences in patient care before you practice independently.

And, I mean, our standards are before you. But supervision is a very important part of this ongoing evaluation. And learning is a very important part of this.

Q. You used the term, "master," I think, as

Page 55

one description of mastering of certain skills. Are there other categories?

I'd like to get kind of the continuum of the categories and talk about where they are when people graduate from medical school and then what the goal of the ACGME standards are in terms of measuring where they are when they graduate from residency programs?

So, first, let's see if we can get kind of is there a continuum that you would use of degrees of skill?

A. There is. We're indebted to Hubert and Stuart Dreyfus who developed a model that we're using. And in their categorization, the continuum begins with novice, advanced beginner, competent, proficient, expert, and master.

Q. Let's talk about each of those individually. What do you mean by, "novice"?

A. Novice is someone who has not yet mastered the rules of whatever skill it is you're trying to learn.

Q. So the novice is asking the question, "What are the rules"?

A. Right. We would think of a novice as

Page 56

someone who has just entered medical school. And advanced beginner --

Q. Just before you go on, what do you mean by, "the rules"? Can you give me an example of a rule in this context?

A. I think, in the case of medicine, it requires a broad knowledge base in all of the relevant sciences.

So anatomy -- it would be good that you know that the liver is on the right side of the body.

Q. Okay.

A. And believe it or not I've seen medical students who thought it was on the left side of the body. It would be good if you knew that the heart was where it is, rather than examining the abdomen for the heart. And so, at a very fundamental level, you learn anatomy. You learn the structure of the human body.

You might, then, learn the function of the human body. "So the kidney, how does it work and how does it manage the excretory products produced by the metabolism of the body? How does the heart pump the blood?" And you sort of learn

Page 57

that in physiology. You learn how the nerves work and how the muscles work.

You then may branch out to learn histology and pathology and look at the microscopic level and see how the human body is structured, microscopically, and how those various cells work.

And then you would advance a little bit to pathophysiology and understand what happens in renal failure. "How does that work? What are the various categories of illness that can affect the kidneys so that the kidneys don't work?" It would be the same with virtually any system in the body -- the neurologic system, the muscular system, the joints, and arthritis, and so on.

Q. So those are that basic information?

A. That's basic information.

Q. And you would refer to that as the rules, knowing the rules?

A. That's one category of the rules. The other category of the rules are things that medical students carry around in their pockets -- as do residents -- called the Washington Manual, which is, "What do you do if you have a patient with a fever?"

And you sort of have a little compendium

Page 58

of things you would do if you were investigating a fever. It's a little checklist. And you sort of, "There I did that."

And so you know the rules of how to do that. "What do you do if the blood pressure drops precipitously? What do you do if someone faints? What do you do if a woman goes into labor prematurely? What do you do if you have abdominal pain."

I mean, the textbooks are each this size, (indicating). And there are hundreds of textbooks. So there are a lot of rules.

Q. Now, are those rules learned before in medical school, or are they learned in the residency program, or both?

A. Both. And, I think, once you achieve a certain level, we would -- on the Dreyfus Model -- consider you an advanced beginner when you enter a residency program.

In other words, you understand the way the human body works, and when it's healthy, and when it's sick, and the various beginning categories of how it gets sick, and sort of a cook book approach of what to do when it does get sick.

Page 59

Q. So if the question that the novice asks is, "What are the rules," what's the question that the advanced beginner asks?

A. They would begin to apply those rules to certain context.

Q. So, "How do I apply the rules"?

A. So, now, I'm your patient. And I actually have a fever. And you begin to sort of think about why I might have a fever. And you begin to apply those rules.

Now, to make sure that you don't kill me, there is -- if, by now, you're a first year resident, say, there might be a senior resident who would also see me, and make an independent determination, and keep an eye on you. And there would be an attending physician who is responsible for my care and who is keeping an eye on the senior resident and on you and has the final authority about what to do next.

So you might think that I have an infection in my kidney causing the fever. But it turns out that I've got an infection on my heart valve; and it has spread widely through my body; and I'm near death.

Page 60

And so maybe you've said, "Well, the urine looked a little funny. And I gave this antibiotic which could cure a kidney infection." But it turns out it's much more complicated than that, and the patient died.

Well, we don't want that to happen. And so we have people who are of various levels of training so that -- for example, a novice learns the most, actually, from an advanced beginner. And an advanced beginner learns the most from someone who is competent. And someone who is competent learns the most from someone who is proficient. Someone who is proficient learns the most from someone who is expert. Someone who is expert learns the most from someone who is a master.

And by the time you're at the master level, you are very attentive to context -- to the particulars of the patient. You've learned the rules a long time ago, and you're current on that.

But you know that a good clinical decision is driven by the particulars of the patient. And these rules are there to help you, but you're not dictated by the rules. You're dictated by the particulars of the patient.

Page 61

So you have to have enough experience with patients with various diseases and various circumstances. Or, if you're procedurally inclined, you have to have done the procedure enough times that you know, and recognize, and are driven by the particulars of the patient rather than by the rules, even though the rules are there to help you.

Q. So if a novice is looking at the rules, what is the advanced beginner looking at then?

A. The rules as applied to context; but in a gentle way for the most part.

You know, if you're a surgical resident, you start with hemorrhoids and you end up doing heart transplants. You don't start with heart transplants. And so you start with simple procedures and master those. And then it gets more complicated.

As you do that, you're applying the rules to simpler cases and then more -- a wider range of cases and cases of deeper complexity -- and then you're competent. So we think -- and the certifying boards require that every program director sign a statement that you're competent. You're not yet proficient. You're not yet an expert. You're not

Page 62

yet a master. But you're competent when you graduate from a residency program.

Q. And by, "competent" -- if the novice looks at what are the rules, and the advance beginner looks at those rules in some context, what does the competent person/physician do?

A. A competent person has applied the rules in enough types of context. "I've seen a wide enough range of patients with varying degrees of severity of illness," that they are now -- in the minds of the experts -- able to practice without supervision and independently.

And they pop out with competent on their forehead. And then the rest of their life they ideally improve those skills and become proficient, expert, and master more and more. And so you will find people who are extremely good with these very complex cases, and they could not do that when they graduated from residency.

But as a mechanism to protect the public, we think you have to be, at least, competent when you come out. And so it requires three -- and sometimes ten -- years of training in order to develop the practical experience you need to

Page 63

function independently.

Q. And to function competently?

A. Yes.

Q. And then -- just so we can complete it -- what do you mean by proficient then?

A. Proficient is -- it's a very interesting term. It is said that, in order to become competent, you have to feel bad. And by that what happens is, you apply the rules; but you're not yet paying enough attention to the particulars of the patient.

So you come in and you're short of breath. And, I say, "Oh, I think this is pneumonia." But I'm wrong. I didn't pay enough attention to you. It's a tension pneumothorax. Your lung has collapsed.

And now you're in big trouble. And someone has to put a chest tube in. And I blew it. And I feel bad. And I could go back to advance beginner and say, "I'm going to develop a new rule. Shortness of breath on Tuesday night is a tension pneumothorax." It's a silly rule, but that's the only one I could develop. And I can manage my behavior with an ever bigger set of rules.

Page 64

Or, I can go back and say, "What did I miss about you," and really get into the details of you and understand how I made that mistake.

In the course of feeling bad, different faculties open up. So it's no longer just my intellect. It's now my intuitive capacities available to me. And I can now be fully present.

So proficient is someone who has those intuitive capacities. They've seen enough that they basically use pattern recognition rather than rules. And, they say, "That's Aunt Evelyn. I've seen it enough. That's Aunt Evelyn."

And then they'll go through a very careful process of proving it's Aunt Evelyn; but they know -- within seconds sometimes -- this is pneumonia, this is a tension pneumothorax, this is a hot gallbladder. And they're using intuitive capacity supplemented by their intellect, rather than just a rule-based approach.

The experts are people who everybody knows who they are because you call them when you're in trouble. So if you're an experienced physician -- now well out of residency -- and you're proficient, and you're a very good doctor, and you

Page 65

find yourself in trouble, you will call an expert, because they have -- they're better than you. And they have more experience in this particular illness. They have -- they can help you.

And a master is someone who has integrated that into their personal style. And so, in the training program -- you can see this in the training program.

So let's imagine that I'm your first year resident and you're my attending. I will get the patient's story. And then I'll present the case to you. But I'll convert the patient's story into a doctor's story.

And then I present a nice coherent story to you. And, you say, "David, that was wonderful. It's clear that you understand the pathophysiology of the disease. Everything you said was orderly, and logical, and coherent."

But to create that doctor's story, I pruned the details of the patient's story that I couldn't explain. And they're on the floor, and I've eliminated those details.

If you look at a master, the only thing they talk about are those details. They say, "I saw

Page 66

the weirdest case last night." And they talk about these unique cases, because they're totally dwelling on the particulars of the patient. And they love these quirky details that actually inform their judgment tremendously.

Whereas, the early learner doesn't know how to explain them. So they don't mention them. And they focus on the explainable doctor's story. And so to get from here to here where you're no longer just trying to create a coherent story, but you're actually trying to help the patients and get into the particulars of the patient -- that's the journey you take to and through competency and beyond.

Q. If the range of the continuum is novice to advanced beginner, to competent, to proficient, to expert, to master -- and that's the continuum that you've described -- what is the goal of the ACGME standards to determine at what level you are when you graduate from a residency program?

A. We do not look at individuals. We look at programs. The certifying boards look at individuals.

So we would judge, in a sense, "Is the

Page 67

program competent; i.e., can it habitually produce competent graduates?" The certifying boards would say, "Is Ted Martin a competent doctor?"

Q. Let's go through that.

If I understood what you said, the ACGME does not accredit individuals. It accredits institutions and programs?

A. Right.

Q. And its goal is to have standards that result in programs that produce competent physicians?

A. Correct.

Q. Not master's and not advanced beginners?

A. Right.

Q. Competent?

A. Right. And they do it habitually; i.e., they're a competent program. This program is habitually producing competent graduates.

Q. So accreditation is about the institutions and the programs. And the individual, then, is certification?

A. Correct.

MR. LYONS: Objection as to form.

MR. MARTIN: Okay. I'll rephrase it for him.

Page 68

BY MR. MARTIN:

Q. Would you explain the difference between accreditation and what that relates to -- and what board certification relates to?

And maybe, if you could, give, maybe, a simple overview; and then we can go into details.

A. An accreditation determines whether a program or an institution meets the published accreditation standards of the ACGME. So the unit of analysis is the program, not the individual.

The certification process determines whether an individual is competent in that particular specialty. So when I finished training, in my internal medicine residency program, I then appeared before the American Board of Internal Medicine and, among other things, took an exam, and became board certified.

They cared whether David Leach was competent. It's a bad example, because I'm old enough that the ACGME didn't exist when I went through. But during that time period, the Residency Review Committee in internal medicine determined that my program was competent, was accredited.

And so that tension between the unit of

Page 69

analysis being the individual or being the program came about historically when certification came first and then people couldn't pass the exams. And it was thought that the profession needed to give more direction to the residency programs, which would enable them to systematically produce graduates who could pass the exams.

And so attention was paid to the program as a unit of analysis.

Q. In order to sit for -- maybe I'll begin earlier.

To become board certified, does a person have to take an exam?

A. Yes.

Q. And to become board certified, are there certain requirements that are common among specialties and subspecialties?

A. In general, there are. You must graduate from an ACGME accredited program in your relevant specialty. You must have a letter -- from the program director -- saying you're competent, and eligible, and that you meet certain professional standards.

And then you appear before the board.

Page 70

And they will either admit you or not to the certification exam.

Q. Okay. And then do you have to pass the exam?

A. Yes, to become certified.

Q. So you've described accreditation of institutions and programs and board certification that individuals can receive.

How is licensing related to either of those two things, if it is?

A. There are three phenomena that it might be helpful to consider -- licensing, certification, and credentialing.

And for all these of those, the unit of analysis is the individual, not the program. Accreditation does programs and institutions.

Licensing -- to get a license to practice medicine, you would go to the various states. And it's actually more than states, because there are, I think, maybe, 79 licensing jurisdictions, or something, because some states have multiple boards.

And you present, to the Licensing Board, evidence that you went to medical school -- either in the United States or in another country -- that

Page 71

you have passed examinations established by not the certifying boards, but by the National Board of Medical Examiners. And those two things get you a ticket into licensure.

Now, a licensure in many states requires only one year of an ACGME accredited program. In many others, it requires two years. And in most states, for international medical graduates, it requires three years.

The states vary. And, again, it reflects our history of states' rights. And so each state determines the criteria for licensure. There's no national licensing body in medicine. Each state determines their own criteria.

In general, those are the criteria. You must spend, at least, some time in an ACGME program. You must have graduated from medical school. You must pass these exams. And you can get a license to practice.

The certification system we've talked about. In that case you have to graduate from an ACGME residency. The credentialing process is done at a given hospital.

And so my license -- for example, I'm a

Page 72

licensed physician -- is unrestricted. I, theoretically, could do a heart transplant. I've never done a heart transplant. It would be really bad for me to do a heart transplant.

MR. LYONS: Not to mention the patient.

BY THE WITNESS:

A. Not to especially mention the patient.

And so to protect the patient, I would go to the hospital, Northwestern Hospital, and say, "I would like to do a heart transplant. Here is my training. I'm an endocrinologist, and I'm fully licensed. And my license says I can do a heart transplant."

They would say, "You can't do a heart transplant. You've never done one. You're not certified by the American Board of Thoracic Surgery. You can't do it."

And so the credentialing committees of the various hospitals vary tremendously. But they determine what you can actually do in their hospital.

Now, there are little chinks in this armor, because increasingly there's ambulatory surgery, for example. And I would not have to go

Page 73

through a credentialing committee. And I could open an office and do something that would actually harm patients.

And so the profession is constantly looking for ways to close those chinks to protect the public. But right now that's an open chink.

BY MR. MARTIN:

Q. And at most hospitals is there a relationship between getting credentials and being board certified?

A. Increasingly, yes, so that there are some hospitals that would not require you to be board certified.

But the vast majority do. I should say the Credentials Committee also requires that you typically graduate from an ACGME residency, and you're board certified, and have a license in good standing.

And in addition to that, they want to see the experience you've actually had in your practice. And then they will recredential you.

So once I'm credentialed to remove gallbladders, on an ongoing basis -- sometimes annually -- the Credentialing Committee of that

Page 74

hospital will look at my experience in removing gallbladders and make sure that I'm still, at least, competent in that.

Q. What you've described so far about accreditation as compared to programs/institutions, board certification of individuals in specialties or subspecialties, licensing of individuals, and credentials issued by individual hospitals, was that true during the period of 1997 through 2004, too?

A. Yes.

Q. Throughout today's deposition, if an answer you're going to be giving would have been different from that period of time, if you could just tell us so that everybody understands it, that will be helpful.

If not we'll just assume your answers are reflective of what was true during the period 1997 through 2004.

A. Just to be clear about that, the six competencies were endorsed in February of '99. So from '97 to '99, that language was not there.

Q. Right. Even though the ACGME had not adopted the six competencies or not begun that process, was the goal of the ACGME still to have

Page 75

programs which produced competent people?

A. Yes.

Q. Competent physicians?

A. Yes.

Q. If the goal of the ACGME is to develop standards that will make sure institutions and programs produce competent physicians, has it looked at how is it that physicians learn to become competent physicians?

A. Yes.

Q. And can you just kind of give an overview of how do physicians learn to become competent physicians? Can you learn that in a book?

A. No.

Q. How do you learn that then?

A. You learn it by practice. You learn it by actually seeing patients who are sick or in need of certain procedures.

And you learn by mimicking people who actually do know what they're doing, and observing them, and then doing it under close supervision, and then doing that in a graduated way so that you are assuming more and more responsibility as you go through the residency program.

Page 76

Q. There was a person -- I believe he was from the 19th century -- named Osler. Are you familiar --

A. Yes.

Q. Is it Dr. Osler?

A. Was.

Q. Are you familiar with the statement attributed to him -- that physicians learn at the bedside?

A. Yes.

Q. Is that, in any way, reflected in the ACGME standards?

A. Yes. We require practical bedside experiences, ambulatory experiences, operating room experiences -- depending on the relevant specialty -- for all of the specialties.

Q. I want to talk about an issue that may have evolved over time; and that is the concept of duty hours.

A. Yes.

Q. The ACGME currently has duty hour requirements; is that right?

A. Yes. Yes.

Q. Now, when you graduated from your

Page 77

residency program, were there duty hour requirements in place?
A. Only at the very highest abstract level. They were not specified.
Q. So can you tell me the evolution of the ACGME's duty hour requirements -- kind of give me an overview of that?
A. Yes. The ACGME has always thought that every patient deserved an awake, alert physician.
And as the practice patterns changed -- and, I think, there are sort of three things that happened that changed the practice patterns.
One was the introduction of DRGs, the payment system that rewarded hospitals for shorter lengths of stay. So the time became compressed in the hospital. When I was in training, the average length of stay might be two weeks. Now, it's two days or three days. It's a much more intense period of time.
Secondly, there were tremendous advances in knowledge and technology and the abilities to help people, which is good. But there's a lot of new things to learn and master, a lot more to be done.

Page 78

And, third, given the financial constraints that hospitals were under, there was less support staff. So the number of nurses was less, and so on.
So it became apparent that residents were doing more in less time with less help; and that the model of sort of living in the hospital -- once the words residents and house officer evolved -- was not adequate, that the workload was too intense.
I mean, when I was a resident, my schedule for four years was, I would come to work, and work for 36 hours, and have 12 hours off, and then come back to work, and work for 36 hours, and then have 12 hours off, and then come back to work for -- I did that for four years. But, in fact, during the night, I would be in an on-call room. And I could easily get -- and always -- not, "always," but almost always -- two to four hours of sleep, and many nights six hours of sleep.
That was not happening anymore. People were working all of the time because of the acuity of patients and because of this compressed time.
So ACGME began with its Internal Medicine Review Committee. And I can't remember the exact

Page 79

date; but it was sometime in the '80s that they introduced an 80-hour limit to the resident duty period in a given week. And then the ACGME in 2003 had duty hour requirements written for all specialties.
So for all specialties, you could not be on duty, in any continuous period, for more than 24 hours -- with a six-hour period after that to do other work, but you couldn't see new patients. And you had to -- you could not be on call more frequently than every third night.
And on average you could not be attending to clinical and educational duties for more than 80 hours a week. And you must have one day out of seven away from the hospital.
So those requirements, for the first time, then, applied across all specialties. That occurred after the period in question for your case, I think. But that's a little bit of the evolution of the duty hours story from ACGME.
Q. Were there any driving factors that led the ACGME to move in this direction that you can recall?
A. There were.

Page 80

Q. You mentioned a number of them. One was --
A. Yes.
Q. -- the changes in --
A. Yes.
Q. -- in the hospital environment, the increasing explosion of knowledge.
A. There were others. In New York there was a case -- the Libby Zion case -- which, on review -- and my only personal opinion was this was a failure of supervision. This was an attending physician who did not come in.
But, nonetheless, a tired resident was involved in the care of a patient who died and, perhaps, didn't need to die. That led to reforms through the New York public health regulations -- the 405 regulations -- to regulate duty hours in the state of New York.
For a long period of time they were not enforced; but they were there. But it was interesting because we monitor programs in New York as well; and there was really no difference. And then, in recent years, those regulations were, in fact, enforced with penalty by the state of New

York.

Other states were beginning to look at this. Like New Jersey proposed similar regulations, again, at the state level. And John Conyers -- a representative from Detroit, Michigan -- was proposing national legislation that would regulate duty hours.

My own thoughts -- and the thought of my organization -- was that it was better that the profession do this than Congress do this. And we thought that for a couple of reasons. One, nobody knows whether 80 hours is the right number.

Dr. Bell of the Bell Commission in New York admits publically that he picked 80 hours out of the air. And it's essentially an arbitrary number. If, in fact, experience were to dictate that, maybe, 60 hours is the right number, ACGME is more flexible in the way it develops requirements and could react to that quicker than taking the bill through Congress with all that that entails.

Also, the apparatus -- the reason the New York regs weren't enforced was, it's very expensive to visit the hospitals and monitor whether all the institutions are complying with the regulations. To

do that, on a national level, would be redundant and needlessly expensive.

So I met with Conyers, actually. And he expressed gratitude that ACGME was doing this. And I expressed gratitude that he created a little umph for us to make this change. But he was happy with the ACGME doing it.

But that, to answer your question, was another set of vectors in play that led us to do this.

Q. The quality of patient care and patient safety, obviously, is a major concern on the duty hour requirements?

A. Yes.

Q. Was there any concern about how limiting the duty hours would affect the educational nature of the programs?

A. Yes.

Q. And tell me about that.

A. Well, there remains concern. And we, in a sense, solved one problem and created another, because continuity of care is very important.

There are times, if I've been watching you very carefully with a serious illness -- and I

see how you react to interventions, and how the illness is unfolding -- that, even though I'm tired, I might be of greater service to you than an equally advanced beginner, competent person, who is rested but doesn't know you at all and is just sort of meeting you for the first time.

And it is true you do get, when you watch an illness closely, certain sources of information that you can't get otherwise. And so you're with the patient in this evolution. So there was concern about the continuity of care. There was concern about whether adequate numbers of patients or procedures could be done.

So, in other words, the surgeons aren't going to change the 500 to 1,000 cases, major cases, that have to be done. But maybe, now, it would take six years, or seven years, or eight years, and extend the length of training in an already very long training period for physicians.

As we've looked at that, we've seen many hospitals adapt in very constructive ways and develop an accountability system that is more dependent on teams of people. And so these hospitals can be very dangerous places. And

residents know that. And some residents feel that the system of patient safety depends on their individual vigilance.

Instead, a new culture is emerging that makes it a team responsibility so that people can go away and rest adequately, without breaching the continuity of care, because there's overlap and a broader number of people familiar with the case.

Likewise, through our case log system -- as I've mentioned, we've got about 4 million cases a year. We have an archive of 40 million cases -- we have not seen dramatic drops in the case volume since we've imposed duty hours. Now, it's still too early to make a definitive statement about that. But we're monitoring this very closely.

There are three areas of concern that we worry about. One is the educational experience, and is that compromised. Another is patient safety, of course, and whether we've done damage by doing this. And the third is resident safety and well-being.

You read periodically about very tired residents driving home from work, falling asleep, and getting into an accident, or just being under acute and chronic sleep depravation to the point

Page 85

their function is impaired.
I think, to your earlier question, another variable that was very important -- in the ACGME's establishing of these duty hour requirements -- was the new science emerging from sleep science, which showed the effects of acute and chronic sleep depravation. And while it is true that people are variable, there is a certain threshold beyond which your human performance is impaired.
And so we could not ignore that data. We had to tell people to go home and sleep. The old model of sort of hanging around and seeing cases was no longer appropriate.
Q. Explain that just for a second. You've talked about the duty hour requirements and some of the counter-balancing issues.
If my son is in the hospital and the resident decides to, you know, leave at 5:00 o'clock, but my son is still showing symptoms --
A. Right.
Q. -- I can imagine that I would have some concern about that.

Page 86

A. Right.
Q. So there is a patient care issue.
But how does that affect the education to the residents? I'm not sure if I understand that.
If the resident goes home at 5:00, how does that help or hurt his educational experience?
A. Well, I think it's true in all cases. But to make the point, let me change from your son to a pregnant woman in labor.
And you've been, now, with her watching her through the various stages of labor. And the minute hand sweeps 12:00, and you walk away. And she delivers an hour later. And you don't get to see the delivery. You don't get to participate in the delivery. Your education has been compromised.
Now, the same principle is true if I'm following a patient with ketoacidosis and I'm manipulating potassium, and various doses of insulin, and so on. And I'm watching them get better. But they're still in acidosis, and it's time for me to go home. I don't get to see the resolution of that acute illness, because illness

Page 87

doesn't go by the clock. And so you're missing the opportunity to see that.
So it is new territory. And we're trying to preserve -- and think we are, actually, preserving -- the educational experiences. But we don't have the right answer on this yet I'm convinced.
And one of the things the ACGME has done is, it's converted its ad hoc task force on duty hours that develop these requirements. And it's, in its stead, put a committee on innovation in the learning environment that's actively seeking out and publishing examples of how you can adapt to duty hours in a way that preserves the education and preserves patient safety and resident safety.
MR. MARTIN: It's five to 12:00. Let's take a break.
(WHEREUPON, the deposition was recessed until 12:53 p.m., this date.)

Page 88

IN THE UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION
UNITED STATES OF AMERICA,)
Plaintiff,)
vs.) No. 1:05-CV-445
UNIVERSITY HOSPITAL, INC.,)
Defendant.)

APRIL 20, 2007
12:53 p.m.

The deposition of DAVID C. LEACH, M.D., resumed pursuant to recess at Suite 4400, One North Wacker Drive, Chicago, Illinois.

PRESENT:
U.S. DEPARTMENT OF JUSTICE,
(PO Box 55,
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MR. TED T. MARTIN,
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appeared on behalf of the Defendant.

PRESENT (CONT'D):
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appeared on behalf of the Deponent.

ALSO PRESENT:
MR. THOMAS C. GENTILE, JR., MSA.

REPORTED BY: JENNIFER L. BERNIER, C.S.R.,
CERTIFICATE NO. 84-4190

DAVID C. LEACH, M.D.,
called as a witness herein, having been previously duly sworn, was examined and testified as follows:
EXAMINATION (CONT'D)
BY MR. MARTIN:
Q. For what years have you been the executive director of the ACGME?
A. Since September 1997 until now.
Q. And prior to 1997, did you participate, in any way, in activities related to Graduate Medical Education?
A. I was a program director from 1984 to 1997; and I was, in ACGME parlance, a designated institutional official from 1984 to 1997.
Q. Thank you. Would you take a look at page 11 of Gentile Exhibit No. 2. That's the green book.
MR. LYONS: 11, did you say?
MR. MARTIN: Page 11, yes.
BY MR. MARTIN:
Q. And I'm going to refer you to, under the subheading, "Introduction." It reads that the ACGME is jointly sponsored by the American Board of Medical Specialties, the American Hospital

Association, the American Medical Association, the Association of American Medical Colleges, and the Council of Medical Specialty Societies.
Do you see that?
A. I do.
Q. Was that true throughout the period --
A. Yes.
Q. -- '97 through 2004?
A. Yes.
Q. And if you see below that, it states, "The mission of the ACGME is to improve the quality of health, in the United States, by ensuring and approving the quality of Graduate Medical Education experience for physicians in training. The ACGME establishes national standards for Graduate Medical Education by which it approves and continually assesses educational programs under its aegis" -- a-e-g-i-s.
And was that true throughout the period of 1997 through 2004?
A. Yes.
MR. LYONS: Objection. It calls for an opinion. But you can answer.

BY MR. MARTIN:
Q. Okay. Well, you knew what the mission was throughout the period; did you not?
A. Yes.
Q. I would like you to look, now, at page 31 of the same exhibit. And you had described for us earlier the three phases of Graduate Medical -- I'm sorry. Strike that.
Looking at page 31 of the same exhibit, you described the three phases of medical education, the second phase being Graduate Medical Education.
And I would like, now, to look at the paragraph that reads, "The single most important responsibility of any program of GME is to provide an organized educational program, with guidance and supervision of the residents, facilitating the resident's professional and personal development while ensuring safe and appropriate care for patients. A resident takes on progressively greater responsibility, throughout the course of a residency, consistent with individual growth and clinical experience, knowledge, and skill."
Was this, according to the ACGME, the single most important responsibility of the program

during the period that we've been talking about?
A. Yes.
MR. LYONS: Objection. I'll move to strike on the basis it's opinion. It does say what you read it into the record to say.
BY MR. MARTIN:
Q. Well, for the period in question, was that how the ACGME viewed its responsibility?
A. Yes.
MR. LYONS: Objection. Calls for opinion.
BY MR. MARTIN:
Q. Throughout the period, was that how the ACGME viewed GME?
MR. LYONS: Objection. Opinion.
BY THE WITNESS:
A. Yes. This is right at the heart of our work and the heart of a Graduate Medical Education program.
And that is what we monitor. That is what is required to begin to become in compliance with our standards.
BY MR. MARTIN:
Q. Do you see the statement, in the next paragraph below, "Educational quality and patient

care quality are interdependent and must be pursued in such a manner that they enhance one another."
A. Yes.
Q. What does the ACGME mean by that?
MR. LYONS: Objection. Calls for an opinion.
BY THE WITNESS:
A. It means, as we talked a little bit about earlier, the linkage between the quality of resident education and the quality of patient care; that if you cannot deliver good patient care, you cannot teach others how to develop their skills in patient care. And so they are interdependent.
Likewise, the patient care is enhanced by having more conversations about the particulars of the patient than any single physician could provide. So there's built into the educational program a reflection on the experiences of the various people encountering the patient, shared conversations, a certain level of discipline, and dialogue that does not occur in the absence of an educational program.
BY MR. MARTIN:
Q. Let's assume a program that wished to be accredited by the ACGME said to you -- to the ACGME -- "It's fine. But we don't want -- we want

to be accredited. But we don't want our residents to have to witness or participate in patient care. But we'd still like them to be accredited."
A. They would not be accredited. The purpose is to organize experiences, in this educational program, in a way that allows for graduated responsibility and accumulation of patient care skills. And you cannot do that in the absence of patients.
Q. And my memory is going to be a little faulty here for a second.
But my recollection is that somewhere -- in either the institutional requirements, or program requirements, or both -- that there are some requirements about the residents receiving stipends?
A. In the institutional requirements, on page 36, Section 2(c)(1), the statement reads, "Adequate financial support of residents is necessary to ensure that residents are able to fulfill the responsibilities of their educational programs."
So we have that requirement in place to ensure that the educational nature of the program is not compromised by a need to support themselves

Page 97

financially by, for example, getting another job or doing that.
Q. Has the ACGME monitored, in any way, the amount of debt that --
MR. LYONS: I'm sorry. The amount of what?
BY MR. MARTIN:
Q. The amount of debt that medical students are entering residency programs with?
MR. LYONS: Objection. No foundation.
BY THE WITNESS:
A. No. ACGME does not, in any way formal way, monitor the debt load of graduates. We read the paper, and other bodies do that.
And we know that residents entering -- medical school graduates entering residency programs typically have a very heavy debt load.
BY MR. MARTIN:
Q. I would like to go back briefly to the duty hour limitations. And in response to the duty hour limitations, the 80-hour limits –
A. Yes.
Q. -- in monitoring that, have you found any tendency of residents to try to seek to circumvent those and participate in the programs more than 80

Page 98

hours a week?
A. Yes. There are some specialties where it's more apt to be the case -- particularly, surgery -- with some residents, in general, for two reasons.
One, they want very much to acquire the experience of surgical cases. And if they're not there, they are missing that experience. And then they also feel a particular obligation to the patient. And if a system is not in place whereby a team of individuals is accountable for that patient, they do not want to abandon the patient.
So, in general, we do survey residents. And we have about 3 percent of the 100,000 residents report working more than 80 hours a week. And if you probe into that 3 percent, that's what you find.
Q. Following up on that, in terms of the residents sometimes seeking to avoid the hour limits because they want the experience, is it your sense that the residents that are in the residency programs are there for the stipend or because they're seeking the education and training?
MR. LYONS: Objection. Calls for opinion and speculation.

Page 99

BY THE WITNESS:
A. Only an insane person would enter a residency to get a job. It is not a job.
It is a prerequisite to independent practice. And it's an intense experience. It is a journey to authenticity as a physician.
And so their motives are to become an authentic physician, but, more practically, to become able to practice independently and to enter the profession in a way in which they've met all of the criteria for entering the profession.
And you would literally have to be insane to enter it for any other reason.
BY MR. MARTIN:
Q. Sometimes the line between opinion and fact is very -- fact testimony is a little unclear.
But just, to the extent you've given any opinions today, do you hold those opinions to a reasonable degree of professional certainty?
A. Yes.
Q. Now, I want to just touch briefly on the six competencies.
And you told me -- told the Court -- a little bit about those six competencies. Maybe, if

Page 100

we could, just go through those so that I understand each of them.
One of the six competencies is patient care that is compassionate, appropriate, and effective; is that right?
A. Yes.
Q. And the second is, am I right, that it's medical knowledge about established and evolving biomedical, clinical, epidemiological, and social behavioral sciences?
A. Yes.
Q. And is the third patient-based learning improvement that involves investigation and evaluation of patient care?
A. You said patient-based. And I think it's practice-based learning and improvement.
Q. And the fourth is interpersonal and communication skills?
A. Yes.
Q. And the fifth is -- do you recall what the fifth is?
A. Systems-based practice.
Q. And the sixth?
A. Oh, the fifth is professionalism; and the

Page 101

sixth is systems-based practice.
Q. How did you develop these -- how did you narrow it down to six?
A. For as long as ACGME has existed, we paid attention to physician competence. In 1999 -- actually, in 1997 the ACGME committed to using the Educational Outcomes as an accreditation tool. And so we went through a process for two years and, in February of '99, deconstructed physician competence into six physician competencies.
That process began with a literature search that identified a potential for 84 competencies. We clustered those into 13 categories, and displayed all 84, and conducted a survey and focus groups of lots of people who know a lot about graduate education, and asked -- for each of the 84 -- "Is this a relevant competence," and, "Is it feasible to measure it?"
And we came back with a narrower list and realized that most of our friends could remember six things; but not all of them could remember seven. And we didn't want this to be in a book. We wanted this to be in people's hearts and minds. And so they had to be able to memorize it.

Page 102

We knew -- and the only reason you sort of deconstruct any phenomenon is to measure it and improve it. And we wanted the world, using our leverage, to begin to measure and improve a broader range of competencies than just medical knowledge and patient care skills.
We wanted them to learn how to analyze their practice and see if they were delivering good patient care. We wanted them to learn the skill of improving in making an intervention to improve patient care and determine whether the intervention was an improvement.
There was a deep hunger for a return to professionalism and the values. When things are in a state of radical change, it's very good to pay attention to -- you know, Dee Hock says, "Substance is enduring. Form is ephemeral. Preserve substance. Modify form. Know the difference."
So the forms of medicine have changed dramatically over the last few decades. But there was a hunger to identify and be clear about the substance of medicine -- i.e., the values of professionalism -- and to be both faithful and effective physicians. And so that is why we picked

Page 103

professionalism.
And in surveys that we didn't do -- but others have done abundantly -- there was, and continues to be, a tremendous need to improve communication skills and interpersonal relations. Not only with patients -- although, especially with patients -- but also with other colleagues.
As care has gotten complex, we've moved from a model of a one-to-one relationship -- doctor and patient -- to, maybe, a twenty-to-one relationship with various types of doctors, and nurses, and physical therapists, and other colleagues.
And communicating actually enhances patient safety. So we wanted to develop those skills. And then we wanted to pay attention to the systems that healthcare is delivered in.
It was not enough to pay just attention to individual competence. You can be a perfectly functioning kidney cell. But if the heart fails, you're going to fail. And that metaphor applies to complex systems where delivering safe and effective patient care depends on more than you.
And so, while we've always been

Page 104

interested in programs demonstrating that they can graduate competent physicians, we thought broadening the agenda a bit, by adding these four other competencies to medical knowledge and patient care, was appropriate; and that the education of the modern physician required that we deconstruct into those six elements and measure -- or have the programs measure, demonstrate that they're measuring them and that they're improving them. So that's why we did that.
Q. Are you aware of any other professional educational programs which are -- strike that.
Are you aware of any other educational programs of other professionals that are evaluated for whether or not they are producing competent individuals or competent professionals?
A. I'm not. I'm aware of the use of different forms of competency-based learning and colleges in the traditional undergraduate colleges. But I'm not aware of really any other profession that has national standards.
So, for example, law and engineering. When you get out of school, you go and work for a law firm, or Motorola, or something like that. And

Page 105

they may have a corporate training program. They usually have some sort of educational program. But it is designed to serve the needs of the corporation and is created by the corporation.

It's not reviewed by a national body. You're not teaching to a national standard. You're teaching to a corporate standard. And there is a wide variability across the various corporations.

I think, as a patient safety issue, medicine is so important that the education programs -- in the Graduate Medical Education period -- must meet national standards and not meet corporate standards. That would take us back to the earlier history that I alluded to where there was a lot of variability in the training and the country was not well served.

Q. A final few questions from me.

It is permissible for people sometimes, who are testifying as experts, to receive compensation for their time.

Are you receiving any compensation from anybody for your time here today?

A. No.

Q. Okay.

Page 106

A. No. I feel that I'm an expert in medical education. But I'm not anybody's expert. I'm not beholding to you. I'm not beholding to the government.

And I feel that, by being just beholding to the truth, I can speak more freely and don't have to shake my arguments to serve either side of the case.

Q. Before today's deposition, you and I spoke.

Did you speak with anybody representing the government before today's deposition?

A. Yes.

MR. MARTIN: I'll pass the witness. Steve, would you like to sit here?

MR. LYONS: No.

EXAMINATION

BY MR. LYONS:

Q. This may be a little late to ask this question. But are you taking any medication that might impair your ability to testify here today?

A. No.

Q. Okay. Mr. Martin just asked you if you had talked to us. And you talked to him.

Page 107

Did you talk to anyone else in preparation for your testimony today?

A. No. I've had conversations with my attorney. But they were -- for example, I have been subpoenaed to be here today, and the subpoena was delivered to him. He told me I was subpoenaed.

Q. Be here --

A. Right.

Q. -- or else, right?

A. Right.

Q. Okay. But that was the extent of your conversations with Mr. Carlson?

A. Right.

Q. Okay. And at lunch today you didn't talk about your testimony?

A. We talked about whether we could get fish and chips in 30 minutes.

Q. Okay. I hope you were successful.

A. We were.

Q. Okay. Did you happen to look at any documents in preparation for your testimony here today?

A. No. I looked at our own, ACGME's, requirements, institutional requirements, and some

Page 108

of the programmatic requirements.

I looked at my CV. I looked at our annual report and our data book just to sort of refresh my memory about things that you might ask me.

But I have not seen, for example, anybody's testimony or even the argument in the case. I have not seen any of those documents.

Q. And this was done at your own behest as opposed to a request from someone else?

A. Correct.

Q. Nobody asked you to look at certain documents?

A. No.

Q. I believe your counsel, Mr. Carlson, was kind enough to inform us of this. But let me just make sure.

In arranging for all of this for the testimony here today, were there any exchange of e-mails with anybody?

A. I don't think so.

Q. Okay. None that you recall?

A. Right.

Q. Okay.

Page 109

A. I would hate to say that. It sounds like I'm a crook. But I don't think that -- I recall no e-mails.
Q. Okay. In this day and age, it's hard to say no e-mails. But it's possible?
A. Right.
Q. Okay. Have you ever been deposed before?
A. Yes.
Q. Okay. A great number of times, a small number?
A. A small number of times.
Q. Two, three, four?
A. Yes, two or three.
Q. And could you just generally describe for me what the reasons for those depositions were?
A. I am an endocrinologist. And my first deposition was about a child with psychosocial dwarfism. And I was called in as an expert to inform the Court about that particular disease.
On another occasion, I was called in as an expert to talk about a case in a malpractice case. I don't think I have been deposed since I have been at ACGME.
Q. So those two are the ones that you

Page 110

remember?
A. Right.
Q. And they were both as expert witnesses?
A. Right.
Q. And you're not appearing here today as an expert; is that correct?
A. Again, I feel like I'm an expert. But I am not -- and I don't know the legal definition of an, "expert."
I'm not being paid. I have not produced a report. I am not defending either side of this case.
Q. Let me rephrase my question. Perhaps, it would be better to ask that you have not been retained by either side as an expert.
A. That's correct.
Q. Okay. And you're appearing here in your individual capacity as opposed to a representative of the ACGME; is that correct?
A. That's correct.
Q. So your views that have been expressed today -- to the extent that they have been expressed -- are those of your own and not necessarily those of the ACGME; is that correct?

Page 111

A. That's correct, with the exception of we've reviewed some institutional and program requirements on the competencies and duty hours. And those words are the official opinion of the ACGME.
Q. That's why I say they may not necessarily be your -- or the views of the ACGME.
Sitting here today, you're not representing the ACGME?
A. That's correct.
Q. Okay. Fine.
Now, I don't know whether your attorney or Mr. Martin has explained this to you.
But you're, obviously, aware that this case is in Cincinnati?
A. Yes.
Q. You're in Chicago. And neither one of us can force you to come to a trial if it comes to that. We're hoping it doesn't, but we never know.
If either Mr. Martin or I, or both of us, had asked you to come to Cincinnati to testify on behalf of either one or both of us, would you be willing to voluntarily come, because we cannot force you to come?

Page 112

A. That's a hypothetical question. And I don't know the answer to it unless it's a real question. And I would have to think about it.
Q. In other words, your answer is, "It depends"?
A. It depends.
Q. Okay. You're not saying, "yes." You're not saying, "no."
A. I'm saying that it depends.
Q. That's fine. Okay. Now, I'm sensing that -- certainly, since 1997 -- you have not been clinically active; is that correct?
A. That's correct.
Q. Up until that point in time, you said, I think, you were a program director at Ford?
A. That's correct.
Q. Okay. And you were also clinically active at that point in time?
A. Yes.
Q. Okay. So your clinical activity, if you will, ceased starting in '97 when you became executive director?
A. That's correct.
Q. Okay. And I believe your Website

Page 113

indicates that you're retiring in September of this year?
A. That's correct.
Q. Okay. Any plans?
A. Yes. We're moving to Asheville, North Carolina.
Q. Up in the mountains?
A. Up in the mountains.
Q. Okay. Moving into the Vanderbilt home?
A. How did you know? If I was going to do that, I would have to be a retained expert.
Q. Will it be a full-blown retirement, or are you just --
A. For 12 months, at least. I'm taking that time to write a little bit, and to reflect, and to celebrate. And then, after that, I don't know what will happen.
Q. Okay. But for 12 months you're just going to enjoy life?
A. I enjoy life every day, but I'm going to enjoy it in the mountains.
Q. Okay. Now, let me just go back for one minute in connection with this expert witness.
Had Mr. Martin's client asked you to

Page 114

appear as an expert in this case?
A. I don't think so. And I'm not clear exactly.
I know I volunteered that I would not be an expert. And I think I did that before they had the opportunity to ask me to be an expert.
Q. Nipped it in the bud, if you will?
A. Right.
Q. Now, as Mr. Martin explained -- in some of his questions to you -- there's a fine line between opinions and facts.
I'm sensing, from your testimony here with Mr. Martin, that your intention was not to give any opinions; is that correct?
A. I don't know the legal definition of, "opinions." And I've sworn and have tried, to the best of my ability, to tell the truth.
Q. Okay. So you're not sure whether you gave opinions or not depending on how you define opinion; is that correct?
A. Depending on how you define opinion. I don't know the legal definition of opinion.
Q. What would you call an opinion?
A. I think I observe various phenomena in

Page 115

this case about Graduate Medical Education -- and I observe it from a national perspective -- and see a lot of what's happening in Graduate Medical Education.
And I also lead an apparatus that conducts 2100 site visits a year; and that develops and holds programs accountable to educational standards. And so, from that point of view, I can share observations that are factual and that reflect personal opinion about what I've observed.
Q. So based on that definition here today, you've both given a factual observation and an opinion observation?
MR. MARTIN: Object to form.
BY THE WITNESS:
A. I think, "both," is the operant word. And I think that there are times, when it's clearly factual, reading and agreeing that those are the words.
And there are times when -- for example, I've talked about the history of Graduate Medical Education. I wasn't there in Colonial America. So I don't have -- I'm reporting the facts that historians have reported.

Page 116

And so I would consider that sort of a factual interpretation of medical education.
BY MR. LYONS:
Q. Okay. Perhaps, I can quote you from another perspective; and that is what you didn't say.
And that is that you're not rendering any opinion here today as to whether these medical residents are more like employees than students in terms of whether or not they can qualify for the Social Security exemption; is that correct?
MR. MARTIN: Objection to form.
BY MR. LYONS:
Q. You can answer.
MR. MARTIN: Sometimes I have to make an objection just for the record.
MR. LYONS: Yeah. That's fine.
BY THE WITNESS:
A. Again, one thing I'm not an expert in is the definition of an employee. And so I have no opinion about that.
I do know that at the very heart of Graduate Medical Education is the student's agenda. And we think, and act, and organized, and behave --

Page 117

on society's behalf -- around the principle that residents are students.
BY MR. LYONS:
Q. And the core of this whole idea is that -- you're talking about the Graduate Medical Education enterprise now, right?
A. Yes.
Q. And at the core of this Graduate Medical Education enterprise is the resident performing this patient care; is that correct?
A. It is the resident being enrolled in an organized educational program that has a curriculum that assesses the resident's development that evaluates and provides highly supervised graduated experiences in patient care.
It is more than patient care. It includes didactic sessions. There are many elements, in the 300 pages of requirements, that don't deal with patient care. But that is one piece of it.
Q. I think that you had said -- in your earlier testimony -- something to the equivalent that without patients and patient care there would be no GME experience; is that correct?

Page 118

A. That's correct.
Q. Okay. So if we don't have patient care, we don't have GME; is that right?
A. That's correct.
Q. Okay. And I think that you had indicated right here, at the very end, that, if a resident had either refused to do patient care or wasn't part of the program, there would be no accreditation; is that correct?
A. If the program did not provide patient care experiences, or if a resident refused to see patients and was not managed by the program, we would withdraw accreditation of that program.
Q. And if the resident had refused to perform the patience care, he'd be immediately fired, right?
MR. MARTIN: Object to the term. Object to form.
BY MR. LYONS:
Q. He would be immediately terminated?
MR. MARTIN: Object to form.
BY MR. LYONS:
Q. Okay. You can answer.
A. I think the reasons why a resident might

Page 119

not want to see a patient are myriad. And I think the organization would come to some decision; and, actually, it probably would not be immediate.
I think our standards would require some sort of probationary period or some opportunity to remediate and to understand the circumstances. And so I think that it probably -- if it, in fact, was not an isolated incident -- would result in the resident being put on educational probation.
BY MR. LYONS:
Q. Let me give you an extreme hypothetical example here.
That is, if the resident refused to perform any patient care, under any circumstances, his contract would be terminated at that point; is that correct?
A. If the resident -- again, I can't second-guess the program. We would review the program and make a determination of whether the program remained in substantial compliance to our requirements.
Q. Okay. Go ahead.
A. So I would need to know the particulars, and I would need to know how the program responded

Page 120

to those particulars. We would keep our eye on the program.
Q. One of the contractual requirements -- and we'll get into the contract later. But while we're here, let me pursue it for a moment.
One of the requirements, in a resident's contract, is that he perform patient care services; is that correct?
A. We have the ACGME template of a contract --
Q. Right.
A. -- on page 36.
Q. That's right. And one of those requirements is that he perform patient care services; is that correct?
A. Could you direct me to the language that you're referring to?
Q. Certainly. I've got the year 1999-2000 one. Let's see here.
Well, I'm assuming that this is the same one. It says here that the agreement must also delineate a reference to specific policies regarding a resident's responsibilities.
Do you see that?

Page 121

A. Yes, I do.
Q. Okay.
A. So we're referring, in the 2000-2001, to 2C, 4A.
Q. Yep.
A. Okay.
Q. And, obviously, from what you have told me today, one of the responsibilities -- and one of the main major responsibilities -- of a resident is to perform patient care; is that correct?
MR. MARTIN: Object to form.
BY THE WITNESS:
A. Your question was suggesting that the resident contract specifies that they must take care of patients.
BY MR. LYONS:
Q. Fine.
A. Our standard requires that the agreement delineate specific policies about resident responsibilities.
Q. Okay. And, most clearly, one of the requirements of the ACGME -- in terms of the resident's responsibility -- is that he perform patient care; is that correct?

Page 122

A. I think that the focus on education requires the presence of patient care. I think the patient care is primarily the responsibility of the attending physician.
And the resident participates and contributes to patient care, but is not ultimately responsible for patient care.
Q. So is your answer that a resident does not have a patient care responsibility?
A. No. My answer was, as I just stated, that the ultimate responsibility for patient care rests with the attending physicians; and that the resident participates in the patient care as a learning experience and as one of the elements contributing to patient care, but does not have ultimate responsibility for the patient.
Q. Then you would agree with me, though, wouldn't you, that a resident has some -- not, maybe, ultimate, but a responsibility -- for patient care; is that correct?
A. The resident has a responsibility to develop their skills; and it is essential that they see patients to do that.
Q. Okay. So let me go back to my question

Page 123

again.
Based on what the ACGME has stated here, isn't it fair to read, at paragraph 4A, that the resident's responsibilities have to be in the contract; and that one of those responsibilities of a particular resident is the performance of some kind of patient care under supervision?
MR. MARTIN: Object to form.
BY THE WITNESS:
A. The first part of your question is certainly correct, that the agreement delineates -- the institutional programmatic agreement with the resident must delineate or reference specific policies regarding resident responsibilities. They are broader than patient care.
BY MR. LYONS:
Q. But do they include --
MR. MARTIN: Wait. Excuse me. Would you let the witness finish, please?
BY MR. LYONS:
Q. Go ahead.
A. They are broader than patient care. They do include patient care. But only as a contributor with others to the care of the patient and only

Page 124

under very careful supervision.
Q. Let me pose the question this way then.
If a resident refused, under all circumstances, to perform any -- and, I mean, "any" -- form of patient care, would he be in violation of the ACGME rules?
A. The ACGME rules hold the program to a standard. They do not hold the resident to a standard.
We would review the program. And if the program didn't make it clear that this is an educational program at the heart of which is acquiring the practical skills needed to practice independently, and that to do that you had to have graduated, supervised encounters with patients -- if they took that off the board and didn't respond to that, we would withdraw the program's accreditation. But we would not have a comment about the resident.
Q. So it is the institution who is responsible for making sure that the contract terms are met, not the ACGME?
A. Correct.
Q. Okay. But I think that, as you've just said a few minutes ago, certainly, one of the

Page 125

requirements that the ACGME has of its residents is that there is a component of patient care involved in the Graduate Medical Education experience?
MR. MARTIN: Objection to form.
BY THE WITNESS:
A. I would agree with that. I would not derive that from the resident agreement. I would derive it from one of the six competencies.
BY MR. LYONS:
Q. They were not there until 1999, though, right?
A. They were not approved by the ACGME board until 1999; and they were not in the requirements until 2000.
Q. So your answer would be only from 2000 forward?
A. No. There's other references, in the various curricular pieces of the requirements, that referred to patient care before the competencies came on board.
Q. Okay. I think, if there's one thing that's clear here today to all of us, it is that patient care is a good part of what you do in Graduate Medical Education, correct?

Page 126

MR. MARTIN: Object to form.
BY MR. LYONS:
Q. Would that be fair?
A. Yes. I mean, we would see it as a violation of the educational agenda. By linking it to the contract, you suggested it was a violation of some other agenda.
And I agree with the conclusion that patient care is part of it because of the educational agenda.
Q. Okay. And so in this case, if the hospital determined that the resident wasn't doing what he was contractually obligated to do, then it would be up to the hospital to determine whether or not they terminate him or not?
MR. MARTIN: Object to form.
BY THE WITNESS:
A. Correct.
BY MR. LYONS:
Q. Okay. I'm going to go to the 1999-2000 one, because that's the one I copied.
MR. LYONS: Can you mark that for me?

Page 127

(WHEREUPON, a certain document was marked Leach Deposition Exhibit No. 2, for identification, as of 04-20-2007.)
BY MR. LYONS:
Q. Turn over to page 30, if you don't mind. And this is going to follow up with where we just were.
By the way, this is part of what I think you referred to as the, "Essentials"?
A. Correct.
Q. Okay. And just refresh my recollection as to what exactly the, "Essentials," are?
A. Well, in particular, you referred me to the institutional requirements.
Q. Okay.
A. There are two general categories of requirements -- institutional and program.
Institutional requirements are designed to set standards for the administrative support of all educational programs in a given institution. And all sponsoring institutions must meet these requirements.
Program requirements get into the

Page 128

particular curricular items of a given specialty.
Q. Okay. So we're talking here, under 2C, about the institutional as opposed to the program requirements?
A. That's correct, and the administrative support for all educational programs.
Q. Okay. And part of the requirements are that there be a contract -- one of the requirements?
A. Correct.
Q. Okay. And this employment contract sets forth certain things -- like the salary that's to be paid, the fringe benefits that are to be received; is that correct?
MR. MARTIN: Objection to form. You called it, "an employment contract."
He's already testified he didn't know whether it was an employment relationship or not.
BY MR. LYONS:
Q. You can answer it.
A. Could you either restate it or --
Q. I'll just have her read it back.
A. Okay.
MR. MARTIN: Same objection.
BY THE WITNESS:

Page 129

A. So the agreement with the resident has to have certain elements in it, as 2C indicates -- including financial support. For example, the stipend that's given to the resident.

And applicants must see the agreement before they commit to join the program. And under C3 it references particular elements of the program.

BY MR. LYONS:

Q. Under C, in the heading, what does it say?

A. "The sponsoring and participating institutions."

Q. No, no. The heading.

A. "Resident Support Benefits and Conditions of Employment."

Q. We have, "Conditions of Employment." And down on three we have a, "Contract."

Wouldn't it be fair to say that what this contract is is a contract for conditions of employment?

MR. MARTIN: Objection to form.

BY THE WITNESS:

A. Again, I'm not an expert on what constitutes employment.

Page 130

BY MR. LYONS:

Q. Okay. You would agree that the words, "Conditions of Employment," appear there in the heading of paragraph C?

A. I do.

Q. 2C?

A. Yes.

Q. Did you write that?

A. No. I didn't write it. It was approved by ACGME in 1998, which probably means the institutional review committee crafted the language. It was read and approved by ACGME at that time.

So it, probably -- with the vetting process and everything -- antedated my arrival. But I did not write it, no.

Q. But you were the executive director?

A. I was.

Q. So you ultimately would have had to approve this, right?

A. No. The board of ACGME has authority over that. In that case I do know what an opinion is.

And I might have an opinion about it. But I would not have to approve it.

Page 131

Q. Okay. Would you have ever looked at it before it went to the board?

A. Yes.

Q. Okay. Do you recall making any changes to it?

A. No.

Q. Okay. So, at least, as far as it was concerned, when it went through your hands, you approved it?

A. I wouldn't use the word, "approved." I had no comment on it.

Q. I suppose, by passing it along without comment, one could conclude that you approved it?

MR. MARTIN: Object to form.

BY THE WITNESS:

A. That's one possible interpretation.

BY MR. LYONS:

Q. Well, let's put it this way. If you had disapproved of it, you certainly would have made a comment on it, I suppose, being the kind of person that you are?

A. I would have rendered an opinion and taken that opinion with the rest of the opinions of everyone -- everybody who commented about these

Page 132

requirements -- to the Program Requirements Committee and then to the board.

Q. But you did make no such comments; is that correct?

A. Correct.

Q. Okay. Well, let me ask you this.

Part of the ACGME requirements of the contract are that the resident be paid. I'll call it a salary. You call it a stipend. Although, in an article, you called it a salary in 1986. But we'll get to that later.

But, anyhow, the ACGME requirements are that the resident be paid a sum of money, be given fringe benefits. And in return for that compensation -- I do believe the word, "compensation," appears in here somewhere -- but at any rate, in turn for these payments, one of the things that the resident is required to do is perform patient care; is that correct?

MR. MARTIN: Object to form.

BY MR. LYONS:

Q. One of the things. Not the only thing, but one of the things?

MR. MARTIN: Object to form.

Page 133

BY THE WITNESS:
A. Again, your question implies -- by, "perform patient care" -- that that's done in isolation. They contribute to patient care as part of a larger unit. And the ultimate responsibility is borne by the attending physician.
I think your reference to compensation does appear under C as, "Compensation of residents and distribution of resources for the support of education should be carried out with the advice of the Graduate Medical Education committee."
BY MR. LYONS:
Q. Yep. I guess my question here is, we have a contract. The contract requires payment of a sum of money to a resident. It requires that the hospital in this case provide fringe benefits. And because it is a contract, there's two sides to this.
And in return for this compensation, the resident has to do something. What does the resident do for that compensation?
A. Acquire the practical skills needed to practice independently.
Q. And one of the things that a resident does to acquire those skills is to perform patient

Page 134

care; is that correct?
A. In the context of a larger unit performing patient care, yes.
Q. Okay.
A. We got into this territory because of the fundamental -- the view of the ACGME is that financial support is provided to maintain the educational agenda.
So the amounts paid, for example, are much less than they would be in comparable professions with comparable experiences. But they have to receive some stipend, because, otherwise -- given their debt load and given the realities of their advanced training programs -- they would, in fact, have to work rather than be in an educational program. And that would compromise the educational program.
THE REPORTER: Hold on one second.
(WHEREUPON, a recess was had.)
BY MR. LYONS:
Q. Let me try one more thing here, and then we'll move on. Let me ask you this.
What would you call an agreement between two parties where one party pays fringe benefits,

Page 135

pays a salary, and in return receives some form of service? What would you call that?
MR. MARTIN: I object to form.
MR. LYONS: Fine. Noted.
BY THE WITNESS:
A. I think that the -- I would not call it what happens in GME. I would think that everything is right until -- I think it's an educational contract.
I think that the exchange of benefits for service may take people down the path of an employment contract. And it's the exchange of benefits for -- and the resident's obligation is more of a duty to the educational agenda, which includes some elements of patient care.
But it is not true to say that this is an exchange of benefits for service.
BY MR. LYONS:
Q. So the hospital got nothing out of this?
A. The hospital is in this because of their educational mission. That is why hospitals do it. We require that they do that. We require that the governing board make this commitment to an educational agenda.

Page 136

There are probably 6,000 hospitals in the United States. There are probably 2,000 hospitals that are actively engaged in Graduate Medical Education. And they have committed to education as a mission, as opposed to the 4,000 hospitals that have not done that. So they're serving their mission.
Q. And in serving that mission, they get large sums of money from the United States government and state governments; don't they?
A. They do get some money from the federal and sometimes from the state.
Q. Large sums in total?
A. In total, I think --
Q. Billions, right?
A. I think in aggregate it's on the order of $6 billion down from $8 billion ten years ago. And so they're getting less.
But I don't think that they are doing it to get money. I think they're doing it to serve their educational mission.
Q. The fact is they do get money. And in '97 through 2004, you said they were getting, approximately, 8, 9 billion?

Page 137

MR. MARTIN: Are you referring to University Hospital getting 8, 9 billion?
MR. LYONS: No. No. In total.
BY THE WITNESS:
A. This is the national.
BY MR. LYONS:
Q. Right, national.
A. And I do not know the amount that University Hospital got.
Q. I'm not asking that.
A. The range is extremely variable. There are well-established teaching hospitals that get zero. There are others that get more money. I think there are -- if your purpose is patient care --
Q. You've answered my question.
MR. MARTIN: No. Please, let him answer the question.
MR. LYONS: No. No. He's already answered my question.
BY MR. LYONS:
Q. Anyhow, Doctor --
MR. CARLSON: Have you finished answering the question?

Page 138

BY THE WITNESS:
A. I think, if the purpose of the hospital is just patient care, there are more efficient ways of doing this and making money than having residency programs.
BY MR. LYONS:
Q. And you had mentioned that there has been a decrease currently in what used to be the payments on a nationwide basis; is that correct?
A. Correct.
Q. Okay. What I want to do is take you back to the years we have, which is '97 -- and then we skipped '98 -- and we go to 2004.
During that point in time, it was more than what it is currently today?
A. I think that's correct.
Q. Okay. Now, has the ACGME always required that a resident sign a -- I'm going to call it an employment contract, but a contract?
MR. MARTIN: Objection to form.
BY THE WITNESS:
A. I don't know the answer to that question. To answer that I would have to go back to 1981 and see the requirements at that point in time.

Page 139

And at that point in time, there were not institutional requirements. There were just program requirements.
BY MR. LYONS:
Q. Okay.
A. So my guess is, they probably did not require that. But I don't know that.
Q. And when they started you're not really sure?
MR. MARTIN: Objection. Form.
BY THE WITNESS:
A. In the late '80s.
BY MR. LYONS:
Q. Okay. Before you got there?
A. Correct.
Q. Okay. And so, at the time that you came there, these contract -- in the words of the ACGME -- these contracts regarding the conditions of employment -- to use the words of the ACGME there -- they were there.
And the conditions were in place for these contracts when you got there?
MR. MARTIN: Objection. Form.
BY THE WITNESS:

Page 140

A. Yes.
BY MR. LYONS:
Q. Okay. Now, these contracts regarding conditions of employment are not signed by medical students; are they?
MR. MARTIN: Objection. Form.
BY THE WITNESS:
A. I don't know that. I don't think so.
BY MR. LYONS:
Q. Okay.
A. Medical schools are quite variable. I don't have a comprehensive knowledge of all of them. But I think you're right.
Q. Okay. At least, as you sit here today, you think they do not?
A. Correct.
Q. Okay. Do you know why that is?
A. No.
Q. Also, under this contract of conditions of employment, the ACGME requires the hospital to provide certain fringe benefits; is that correct?
MR. MARTIN: Objection to form.
BY THE WITNESS:
A. Correct.

Page 141

BY MR. LYONS:
Q. Okay.
A. It requires the sponsoring institution to provide it --
Q. And in --
A. -- which may be a hospital. It may not.
Q. In this case the contract is with the University Hospital.
A. (Whereupon, no verbal response.)
Q. Okay. Medical students don't get fringe benefits; do they?
MR. MARTIN: Objection to form.
BY THE WITNESS:
A. Again, I don't know. I think they are protected in cases of liability. And if a medical student has a needle stick and gets AIDS, they're protected under some form of disability. I don't know the nature of that.
But they also have call rooms, for example, when they're taking call at night. So I don't know what you mean by, "fringe benefits." They are protected so that their educational mission is enabled.

Page 142

BY MR. LYONS:
Q. Sick or annual leave, they don't get sick or annual leave?
MR. MARTIN: Objection to form.
BY THE WITNESS:
A. They may. I don't know. But if a medical student gets sick, they go home and lay down, or they go in the hospital, or they do whatever they need to do to get better. And they're not kicked out of medical school because of that.
BY MR. LYONS:
Q. One thing for certain is they're not paid; is that correct?
MR. MARTIN: Objection to form.
BY THE WITNESS:
A. I think that's correct.
BY MR. LYONS:
Q. Okay. Turn over to page 25 of --
MR. LYONS: Jennifer, what did we call this, Exhibit 1?
THE REPORTER: The first one I marked was 1.
BY THE WITNESS:
A. That's 2.
MR. LYONS: So we're up to -- this is 3?

Page 143

THE REPORTER: Yes.
MR. MARTIN: No. That's 2, I believe, Steve.
BY MR. LYONS:
Q. All right. On page 25 there, under B, "Graduate Medical Education," it says there -- and I quote -- "The programs are based in hospitals or other healthcare institutions."
Do you see that?
A. I do.
Q. Okay. Once again, this is.the ACGME Essentials?
A. Correct.
Q. Okay.
A. This is the preface to the Essentials, correct.
Q. Okay. But it's part and parcel of the Essentials?
A. It is.
Q. Okay.
A. It's descriptive. It's not a standard. But it's a descriptive preface to the standards.
Q. Anyhow, that part of that sentence that I just read indicates that GME programs are based in healthcare institutions, or hospitals, or other

Page 144

healthcare institutions.
But they're based in healthcare institutions?
A. Correct.
Q. Okay. As far as you know, that's a correct statement?
A. Yes.
Q. Okay. And healthcare institutions don't include medical schools; do they?
A. No.
Q. Okay. And the reason that the GME programs are based in healthcare institutions -- at least, one of the reasons -- is because of the need for patients, and patient care, and the GME experience; is that correct?
A. Correct.
Q. And down -- let's see, one -- to the third paragraph there on that page, there is a sentence in there that says -- and I quote -- "The quality of this experience, the GME experience, is directly related to the quality of patient care, which is always the highest priority."
Do you see that?
A. I do.

Page 145

Q. Is that a correct statement?
A. In the context of the paragraph, the education of resident physicians relies on an integration of didactic activity in a structured curriculum with diagnosis and management of patients, under appropriate levels of supervision and scholarly activity, aimed at developing and maintaining life-long learning skills.
The quality of this experience is directly related to the quality of patient care, which is always of the highest priority. Educational quality and patient care quality are interdependent and must be pursued in such a manner that they enhance one another.
A proper balance must be maintained so that a program of GME does not rely on residents to meet service needs at the expense of educational objectives.
Q. So if I read this correctly, in the context in which you just stated it, patient care is always of the highest priority; is that correct?
A. Correct, in the context in which I just read this, that's correct.
Q. And that's because a medical resident can

Page 146

only get through, successfully, a residency program if patients and patient care are available; is that correct?
A. That is one element of it. I think another is that, for example, a junior resident doing something they are not adequately prepared to do would compromise patient quality.
And we don't want them to use an educational agenda to threaten patient care. They can't get an experience just to get an educational experience.
Q. That's what attendings are for, right?
A. Right. Right.
Q. Okay. I guess another reason why the programs are based in healthcare institutions is because -- as opposed to medical schools -- no patient care goes on in a medical school; would that be fair?
A. If you think of a medical school as a building, that is usually true. If you think of a medical school as including senior -- junior and senior -- medical students, they usually function in healthcare institutions, because part of the medical school curriculum requires that as well.

Page 147

Q. But, once again, that's done in a hospital setting and not in the medical school, itself?
A. Correct.
Q. Okay. Let me have you turn over to page 31. Do you see paragraph D down there?
A. Yes.
Q. It talks about work environment?
A. Yes.
Q. Okay. And it states that institutions must ensure that the GME programs provide appropriate supervision, as well as a duty hour schedule, and a work environment that is consistent with proper patient care; do you see that?
A. Yes.
MR. MARTIN: Actually, the rest of the sentence reads, "Consistent with proper patient care, the educational needs of residents, and the applicable program requirements."
MR. LYONS: Okay. You can ask him a follow-up question, if you want. I'm focusing --
MR. MARTIN: No. No. You didn't read the whole sentence.
MR. LYONS: I did that on purpose, because I'm

Page 148

not going to ask him about that. You can ask him about that, if you want.
MR. MARTIN: I'm sorry. I thought you just didn't see it.
MR. LYONS: I'm quoting a portion of it that I want to ask him a question about.
BY MR. LYONS:
Q. At any rate, that statement there -- first of all, is that an accurate statement?
A. Yes.
Q. Okay.
MR. CARLSON: Could we clarify? The statement that you just read or the one that he's reading?
MR. LYONS: Okay. I'll clarify that for you, Doug.
MR. CARLSON: Thank you. Excuse my interruption.
MR. LYONS: No. Not a problem. Not a problem.
BY MR. LYONS:
Q. Okay. Let me see if I can understand what this really is saying here.
It is that here, again, we're in the institutional part of the Essentials, right?

Page 149

A. Correct.
Q. That the institution must provide a work environment that is consistent with proper patient care; is that correct?
MR. MARTIN: Objection. Form.
BY MR. LYONS:
Q. You can answer.
A. Yes.
Q. Okay. Fine.
So would it be fair to say that -- at least, according to paragraph D here -- the part we're talking about is that the patient care takes place in a, quote, "work environment," according to the ACGME?
MR. MARTIN: Objection. Form.
BY THE WITNESS:
A. The part of the sentence and paragraph that you've read says the GME programs provide appropriate supervision for residents, as well as a duty hour schedule and a work environment, that is consistent with proper patient care.
BY MR. LYONS:
Q. And my question was, that means, then, that the patient care will take place in a, quote,

Page 150

"work environment"?
A. Correct.
Q. Okay.
MR. MARTIN: Objection to form.
BY MR. LYONS:
Q. Let's flip back over to page 28 for just a second. Yeah. Right up at the very top under, "Paragraph," it would be 3C.
Do you see, it says, "Sponsoring Institution"? And then, it says, "The institution that assumes the ultimate responsibility for a program of GME"?
A. Yes.
Q. Okay. That's the ACGME's definition of a sponsoring institution?
A. Yes.
Q. Okay. So that means that -- just speaking generally first -- that the sponsoring institution has the responsibility for everything that goes on in the program; is that correct?
A. Correct.
Q. The ultimate -- quote, "ultimate responsibility."
So that would mean that it would have the

Page 151

responsibility for both the day-to-day activities of the program, as well as executive and policy decisions that are made with respect to that program?
A. More accurately, the sponsoring institution has ultimate authority for all of the programs.
Each program has a program director, who has the executive responsibility for that program. And then the sponsoring institution reviews every program --
Q. Okay.
A. -- to make sure it's compliant with ACGME institutional requirements.
Q. So to just clarify in my mind, then, the ultimate responsibility -- and I include ultimate to be from the day-to-day operations of the programs and including and up to executive policy decisions -- ultimately rests with the sponsoring institution; is that correct?
A. Correct.
Q. Do you know who the sponsoring institution is in this case?
A. I did not look it up. I think it is the

Page 152

hospital, but I don't know that for sure.
Q. University Hospital?
A. Okay.
Q. Okay. So in this particular case, then, it would be University Hospital who had this ultimate authority, if you will, if they were the sponsoring institution?
MR. MARTIN: Objection to form.
BY THE WITNESS:
A. Through the Graduate Medical Education Committee; but, yes.
BY MR. LYONS:
Q. Okay. But, ultimately, as someone might say, the ball stops there?
MR. MARTIN: Objection to form.
BY THE WITNESS:
A. I think the ball stops when the Institutional Review Committee says, "You're in compliance with the institutional requirements, or we withdraw accreditation."
BY MR. LYONS:
Q. I'm just trying to see if this definition places the ultimate responsibility for all of the programs on the sponsoring institution.

Page 153

A. Yes.
Q. Okay. And that's in the broadest sense of ultimate responsibility?
A. Yes.
Q. Okay. Do you recall what page the six competencies were on?
Not on the Exhibit 2. By the way, you can give Exhibit 2 back -- for the time being -- to Jennifer.
MR. LYONS: You're the keeper of the pile, right?
THE REPORTER: Yes.
BY THE WITNESS:
A. This is Exhibit 1.
BY MR. LYONS:
Q. I know you referred to them --
A. This, (indicating).
Q. -- the six competencies.
A. Gentile 2 is early enough. Let me make sure that it has the competencies in it -- because it may not -- because the institutional requirements in Exhibit 2 were approved in September of 1998. And that antedated the competencies.
Q. Okay. So it may not have it. Okay. No

Page 154

problem.
I've got them copied for a later year. Why don't I just go with that?
A. Okay.
(WHEREUPON, a certain document was marked Leach Deposition Exhibit No. 3, for identification, as of 04-20-2007.)
BY MR. LYONS:
Q. On page 19 of what is the 2005-2006 Essentials, there is listed -- under paragraph D -- the six competencies?
A. Yes.
Q. Okay. Now, if I understood your testimony early this morning about the six competencies, this is still a work in progress?
A. It will be forever a work in progress; but these competencies were established and have been stable now for several years.
Q. Okay.
A. What makes them a work in progress is developing more sophisticated tools to evaluate them and to track resident experiences.
Q. Okay. And I think there's some 2011

Page 155

deadline for something like that?
A. Correct.
Q. Okay. So a part of the competency project, if you will, is still evolving?
A. Correct.
Q. Okay. Now, I noticed that the very first competency is patient care.
A. Correct.
Q. Okay. That was a conscious decision, on the part of the ACGME, to make it first?
A. It does not mean it's first in importance. In fact, other organizations change the order. We don't prioritize them. All six are required.
Q. Okay. But it has always been -- since they were published in 1999, patient care has always been listed first; is that correct?
A. No. In fact, the American Board of Medical Specialties adopted the same six competencies, but listed -- and continues to list -- medical knowledge first.
Q. I'm talking ACGME.
A. Yes. It's always been first at ACGME.
Q. Okay. And since that's all we're talking

Page 156

about here today -- okay. And is your statement -- well, let me back up.
Is there a reason why it was listed first?
A. No. As I said all six competencies are of equal importance, and we insist on the whole.
Q. Would it be fair to say that a common thread that runs throughout all six of these competencies is patients and patient care?
A. It would be equally fair to say that communication skills runs through all of the competencies.
Q. That wasn't my question.
A. So --
Q. My question was, would it be fair to say that a common thread -- a common thread -- that runs throughout all six competencies is patient and patient care?
A. Yes.
Q. Okay. And I think that earlier in our conversation you indicated that no patient care, no GME experience; is that correct?
MR. MARTIN: Excuse me. I'm sorry. I didn't hear the question.

Page 157

MR. LYONS: You can read it back.
(WHEREUPON, the record was read by the reporter.)
MR. MARTIN: Objection. Form.
BY MR. LYONS:
A. Let me restate it, because what she took down and what I said, I think, were just a little bit different.
BY MR. LYONS:
Q. In our prior conversations, I think that we had agreed that without the patient care element of the GME experience there would be no GME experience; is that correct?
MR. MARTIN: Objection to form.
BY THE WITNESS:
A. Correct.
BY MR. LYONS:
Q. And as far as this patient care element of the six competencies, that competency is obtained through the performance of patient care services; is that correct?
MR. MARTIN: Objection. Form.
BY THE WITNESS:
A. The resident is obligated to require the

Page 158

skills of patient care. And it is that those skills are acquired in a variety of ways, including direct contact with patients under appropriate supervision.
BY MR. LYONS:
Q. So one way to acquire the patient care competency would be to, in fact, perform patient care; is that correct?
A. Under appropriate supervision.
Q. I think some people have said or characterized it as learning by doing?
MR. MARTIN: Objection to form.
MR. CARLSON: Is that a question?
MR. LYONS: That is a question, yeah.
BY MR. LYONS:
Q. Would it be fair to say that patient care skills -- in part, at least -- are acquired by doing the patient care; i.e., learn by doing?
A. I think direct contact with patients is crucial to developing the skills of patient care.
I think doing patient care implies more than the -- it implies a broader set of contributors than the resident, including the attending physician, and senior residents, and nurses, and the whole healthcare team.

Page 159

Q. But the learning process, itself, if you will -- as far as the patient care is concerned -- is accomplished -- at least, in part -- by performing patient care?
MR. MARTIN: Objection to form.
BY THE WITNESS:
A. So the resident sits with the patient, gets a history, examines the patient, reviews the laboratory data, presents that to an attending physician and others. And the way the resident learns is to sit, and interview, and examine the patient.
But it could be very, very bad learning to just sort of go and take care of a bunch of patients by yourself -- when you don't know what you're doing -- and there's no supervision.
BY MR. LYONS:
Q. Let's take the surgeon, for example, the 500 to 1,000 procedures that he must perform in order to get a completion certificate.
And I assume what you're saying there is he must perform these procedures under supervision; is that correct?
A. Correct, and in a graduated way so that

Page 160

the first year resident is doing simple cases and the chief resident is doing more complex cases.
Q. But, nevertheless, at each level he is, quote, "doing," in some form or fashion?
A. In some form.
Q. Okay. And in a graduated way?
A. In a graduated way, under supervision with others.
Q. Okay.
A. Right.
Q. Now, you had mentioned earlier that -- I think you said on average there was about 3.7 years between reviews of a particular institution's residency program; is that correct?
A. Correct.
Q. Okay. So if my numbers are correct, that would mean that there are, approximately -- I don't have a calculator here -- but, approximately, 2,000 reviews a year?
A. Correct.
Q. Okay. Because I think you said there was, roughly, 8,000 programs?
A. That's correct. There are, roughly, 8,000 programs. We do about 2100 site visits a

Page 161

year.
Q. Okay. And during the course of those site visits, the ultimate result could be full accreditation to termination?
A. Just for clarity, none of that happens during the site visit. And the site visit report with other data is presented to the Residency Review Committee.
And their action is expressed in a notification letter, which includes the options you've mentioned. Okay.
Q. Ultimately, each one of these 2100 site visits could result in complete accreditation, or in complete nonaccreditation, or somewhere in between?
A. Hypothetically, yes.
Q. Okay. I don't know whether you have mentioned it today or not, because there's been a lot of organizations mentioned.
But you're familiar with an organization by the name of AAMC?
A. Correct.
Q. That's the American Association of Medical Colleges?
A. Correct. The Association of American

Page 162

Medical Colleges, yeah. Right.
Q. Okay. And one of its former presidents is a fellow named Dr. Jordan Cohen?
A. Correct.
Q. A good friend of yours?
A. I know him very well.
Q. A long time?
A. For several years. I've never been to his house and had dinner with him. I don't know what your definition of a friend is. But we are friendly.
Q. Okay. You know him?
A. I know him. Okay.
Q. Okay. Know him to be a competent administrator?
A. Yes.
Q. Okay. Well-respected, as far as you know?
A. Yes.
Q. Okay. Dr. Cohen, like yourself, has written a lot of articles. You know that, right?
A. Yes.
Q. Okay. Let me hand you one of them.

Page 163

(WHEREUPON, a certain document was marked Leach Deposition Exhibit No. 4, for identification, as of 04-20-2007.)
MR. CARLSON: I don't know if you've read it or not. But I'm sure Mr. Lyons will give you ample opportunity to read it --
MR. LYONS: Sure.
MR. CARLSON: -- as is necessary to respond to his questions.
BY THE WITNESS:
A. Thank you. Thank you.
BY MR. LYONS:
Q. That looks like Jordan?
A. It does.
Q. Okay. Okay. In the -- one, two, three, fourth -- fourth paragraph starting off, "By contrast," Dr. Cohen notes that, "While there have been many changes over the years in technology," and so forth, he notes -- and I quote -- "The structure of residency training has changed hardly at all even with the long overdue restrictions on duty hours."
Do you see that?
A. I do.

Page 164

Q. Do you agree with that statement?
A. Not in -- this was written in January of 2005.
Q. Right.
A. And, no, I don't agree with that entirely.
Q. Okay. What is it that you disagree with your long-term friend?
A. I think the change in residency training has been both incremental and quantum; and there were significant incremental changes in residency training over the 40 years Dr. Cohen is referring to.
Q. He's referring to the structure of the residency program, not the incremental changes. And my reference is that the structure of residency training programs, he states, "has changed hardly at all."
And that's the question I have for you is, do you agree with that statement that the structure of residency training has changed hardly at all?
MR. MARTIN: Object to form.
BY THE WITNESS:

Page 165

A. No. I don't agree.
For example, the Internal Medicine Residency Review Committee, in this period that he's talking about, put in place requirements for associate program directors. They restricted the number of patients that residents can see. They had more to say about the faculty.
Dr. Cohen, himself, was at one time -- before I came to ACGME -- the Chair of the Residency Review Committee in Internal Medicine. And he, himself, wrote requirements that insisted on teaching rounds being discrete and protected.
I would consider that a significant structural change, even if he doesn't.
BY MR. LYONS:
Q. Okay. So you have a, quote, "difference of opinion" --
A. Correct.
Q. -- if you will? Whatever, "opinion," is?
A. Correct. That's right.
Q. Let me ask you this.
One thing that hasn't changed over the years is, that the learning process has always evolved -- at least, in part -- from patient care

Page 166

services?
A. Correct.
Q. Okay. In that sense, that structure has never changed?
A. As you said earlier, that's a thread that's been constant throughout residency education.
Q. Okay. Perhaps, you would have to wait for Mr. Cohen to opine on that. But maybe that's the structure he's talking about.
Who knows? But, anyhow, I appreciate your comments.
MR. CARLSON: Could you read the question back? I don't know if that ended with, "patient care," or if there was a, "services," stuck in there.
(WHEREUPON, the record was read by the reporter.)
MR. LYONS: And his answer was, "yes."
MR. CARLSON: I know. I wanted to make sure he heard the whole question, too. Thank you.
BY MR. LYONS:
Q. Now, over this same period --
MR. LYONS: Excuse me. You know what? Do you want to take a five-minute break?

Page 167

MR. MARTIN: Yes.
(WHEREUPON, a recess was had.)
BY MR. LYONS:
Q. Right when we broke we were talking about Dr. Cohen's 40 years and so forth. And let me ask you this.
Prior to, let's say, 1998, 1999, were you aware of any programs, residency programs -- Graduate Medical Education residency programs, with the exception of those who hired public employees -- who are not paying Social Security taxes, if you know?
MR. MARTIN: Objection to form.
BY THE WITNESS:
A. I don't know.
BY MR. LYONS:
Q. You just have no knowledge one way or the other?
A. That's correct.
Q. Okay. That was an issue that you just never got involved in?
A. No.
Q. Okay.
A. I really know nothing about it.

Page 168

Q. And the ACGME has never been involved in that issue either; has it?
A. No. As stated we do view residents as students; but we have not paid attention to whether FICA payments are made or not.
Q. Just so I'm clear here, from the ACGME's perspective, they've never taken the position as to whether these payments to residents, during Graduate Medical Education, should or should not be subject to FICA tax; is that correct?
A. We have no opinion about whether the stipends are subject to FICA payments or not.
Q. Okay. And since its inception in 1981, the ACGME has never tailored or structured its institutional and program requirements in an attempt to either come within or come without the Social Security system with respect to the resident payments; is that correct?
MR. MARTIN: Objection to form.
BY THE WITNESS:
A. Right. That's right. We have no knowledge of the Social Security payment system.
As already stated, we view the residents as students. We do not know the implications of

Page 169

that vis-a-vis FICA payments.
BY MR. LYONS:
Q. And in putting together all of these 380-some pages every year of information, no thought was ever given one way or the other as to whether or not these payments would be subject to Social Security; is that correct?
A. No. No thought was given into whether the stipends would be subject to Social Security. That's correct.
MR. LYONS: Okay. What are we up to, Jennifer?
THE REPORTER: 5.
MR. LYONS: Mark that.
(WHEREUPON, a certain document was marked Leach Deposition Exhibit No. 5, for identification, as of 04-20-2007.)
BY MR. LYONS:
Q. Doctor, I'm sure --
MR. MARTIN: Is the rest of the case available? Maybe it's just my copy.
MR. LYONS: No. No. No. No. I have purposely just picked out the portions I'm going to

Page 170

ask him questions about.
MR. MARTIN: I object to the use of the document.
MR. LYONS: That's fine.
MR. MARTIN: And providing it to the witness without giving him the whole document.
MR. LYONS: That's fine.
BY MR. LYONS:
Q. Doctor, at the very top --
MR. CARLSON: Have we established that he's seen it before? I don't know that he answered that.
MR. LYONS: Oh, I'm sorry. I'm sorry.
MR. CARLSON: Yeah, sure.
BY THE WITNESS:
A. I have not seen this before.
BY MR. LYONS:
Q. You have not seen it. Okay.
MR. CARLSON: Do you want him to read it so that he can answer your questions?
MR. LYONS: Let me do this, Doug, if it's okay with you.
Let me direct him to the portion I'm going to ask him questions about. And then he can tell me, "I need to read this," or, "I need to do

Page 171

that." Is that okay?
MR. CARLSON: Yes, it is.
BY MR. LYONS:
Q. There is a time and date stamped across the top of each page, some numbers.
And the first one I'm going to direct your attention to, it says, "page 4 of 30." It's going to be the second -- I believe it's the second page here of that exhibit. Do you see that?
A. I do.
Q. Okay. And the -- let's see -- the second full paragraph, just read that to yourself, please.
A. Just to be clear, the paragraph beginning, "The Sixth Circuit."
Q. Yeah.
A. Okay.
Q. Okay. And I want to focus on the statement in there where the Court held that the sums paid to residents were wages because they were in return for the performance of very valuable services; i.e., patient care.
Do you agree with that statement?
MR. MARTIN: Objection to form.
MR. LYONS: Sure.

Page 172

BY THE WITNESS:
A. I don't know this case at all. I don't know whether residents were paid sums.
I don't know whether they were paid in return for anything. So I can't comment on this statement.
BY MR. LYONS:
Q. Okay. Let me generalize the question for you.
Based on everything you know about the ACGME -- the residency programs for Graduate Medical Education -- do you believe that the payments to the residents were in return for the performance of very valuable services; i.e., patient care?
MR. MARTIN: Objection. Form.
BY THE WITNESS:
A. In general -- and, again, I know nothing of this particular case. But, in general, stipends paid to residents are not in exchange for, quote, "very valuable services; i.e., patient care."
BY MR. LYONS:
Q. Okay.
A. They are educational stipends. In fact, we have requirements that will cite programs, if

Page 173

there is an excessive reliance on patient care duties, such that the educational agenda is compromised.
Q. But that's not to say that there would be no patient care services. Only that there has to be this happy medium between education and patient care services?
MR. MARTIN: Objection. Form.
BY THE WITNESS:
A. There would be no patient care, rather than patient care services. I think patient care is a crucial part of residency education.
BY MR. LYONS:
Q. Patient care clearly includes patient care services rendered by a resident, right?
MR. MARTIN: Objection. Form.
BY THE WITNESS:
A. No. It does not. I think the patient care services implies giving a service to a patient.
And a novice learner interviewing and examining a patient may contribute and detect observations not detected by others; but they are not primarily delivering patient care services when they are in direct contact with patients.

Page 174

BY MR. LYONS:
Q. What would you call a surgical resident who performs an appendectomy under the supervision of an attending? Is that patient care service?
A. That's direct patient care. And if the attending is supervising properly, the service is rendered to the patient.
But to claim that a resident is providing direct service to the patient is not uniformly true.
Q. In my example, though, if the surgical resident is operating on a particular patient, that is patient care in your view -- patient care service in your view?
MR. MARTIN: Objection to form.
BY THE WITNESS:
A. That's a form of direct patient care, but in this instance includes experience in the operating room.
BY MR. LYONS:
Q. You seem to be unwilling to use the word, service?
A. Service implies a transaction between the patient and the provider so that the patient care service is provided in exchange for payments for

Page 175

patient care services. And that is not at all the case in residents.
Q. Okay. But let me see if I can be clear here.
In my hypothetical where the surgeon actually cuts the appendix out, sews the patient back up, and sends him on his way, would you consider that as patient care service?
A. Not -- no, not necessarily. I think, again, the entire encounter -- diagnosing the appendicitis is present, getting the right laboratory tests, making a judgment about whether surgery is needed, performing the surgery, providing postoperative care, all of that -- is borne by the attending physician.
The resident is having direct contact with patients -- in this case in the operating room -- and doing things where they're learning. But the attending physician is providing the service.
Q. Even though he's just watching?
A. Correct.
Q. And you're suggesting that this resident, who actually cut the person open and sewed him back

Page 176

up, is not performing a patient care service?
A. Not -- no. If they were to do that, and submit a bill for patient care services, and didn't yet acquire a license to practice medicine, they would be guilty of assault.
Q. Suppose this was a licensed doctor, who was doing the surgical procedure, who was a resident?
A. If they were providing patient care services, there would be no need for anybody else.
Q. Let me ask you this. Are you saying that, in order to provide patient care services, you must be licensed and you must be able to bill for the service?
A. I think I'd have to think about that a little longer. But, yes. That's right.
Q. Okay. So in that case, then, your view would be that residents could never perform patient care services because they can't bill for their services?
A. Correct. They provide encounters with patients. They have direct patient contact. They provide elements of what is habitually done by those providing patient care services.

Page 177

But they are inadequately prepared to provide full services to the patient.
Q. Now, the attending physician can bill for the services performed by the resident, though, right?
A. The attending physician provides services performed by the attending. They may delegate some of those responsibilities to others.
Q. For example, residents?
A. Again, under supervision. And there are others they can delegate things to -- physician assistants and so on.
Q. Okay. Can you turn over to what's denominated as page 9 there?
Do you see where it says, "page 9 of 30"?
A. I do.
Q. Okay. Would you just look at that -- the first paragraph there -- where it starts, "Moreover"?
Just read that to yourself for just a moment, please.
A. It begins --
Q. "Moreover, although."
A. Okay.

Page 178

Q. Just read that to yourself.
MR. MARTIN: I would object to the use of this exhibit without giving the witness the benefit of the full paragraph. Objection to the form.
MR. LYONS: It's on the previous page.
MR. MARTIN: The full document.
MR. LYONS: The full document is a different thing.
BY THE WITNESS:
A. Okay.
BY MR. LYONS:
Q. All right. There the Court notes that there is an educational component to Graduate Medical Education. It's through the resident's patient care that the educational component is achieved. Do you see that?
A. I do.
Q. Do you agree with that statement?
A. The patient care -- direct encounters with patients is an element of the educational component. So it is an educational component. It's not the entirety of the experience.
Q. But it's a part of it?
A. Correct.

Page 179

Q. Okay. So the Court's statement that this educational component is achieved through patient care is accurate as far as you know?
A. It depends. I can't tell, from this paragraph, what the larger element is that they are describing of which there is an educational component.
I think the resident's entire experience is education. And the fact that the wording is such that they say, "educational component," suggests that there is a noneducational component. And with that I don't agree.
I think education is a full-time duty of the resident and of the residency program.
Q. Did I hear you correctly to say that, as far as you are concerned, your opinion is that there is no component to the GME other than education? There is nothing else?
A. Correct.
Q. Okay.
A. It includes direct contact with patients. It includes didactic experiences.
But it is a consuming experience to achieve the skills necessary to practice

Page 180

independently.
Q. I think you told me earlier, though, that this educational component is achieved -- at least, in part -- through patient care; is that correct?
A. No. I think I agreed to the fact that patient care is a component of the educational experience rather than saying the educational component which, again, implies there is a noneducational component.
Q. I've got to digest that one for a minute.
And then I think you did suggest to me, though, that, if we remove the patient care element from the Graduate Medical Education experience, we have no Graduate Medical Education experience; is that correct?
A. That's correct. It would be a fatally incomplete graduate education experience.
Q. Okay. Fine. Let me just follow up just with that last question.
Because you can't have a GME experience without patient care, wouldn't you agree with me that patient care is a component of the GME experience?
A. Yes.

Page 181

Q. Okay.
A. What I was not agreeing to was that there was an educational component and a noneducational component.
But I do agree that patient care is a component of the Graduate Medical Education experience.
Q. And patient care is one form of obtaining this learning experience, if you will?
A. Correct.
Q. Okay. I'm sure that, over the years that you've been the executive director, you've traveled to many of these different GME sites; is that correct?
A. That's correct.
Q. Okay. You've been to University Hospital, I assume?
A. Actually, I don't believe I have.
Q. One of the few?
A. There are 8,000 of them, and I have not been to all of them.
Q. All right. Oh, I thought you said there was only 1274 actual sites with 8,000 programs?
A. Sponsoring institutions.

Page 182

Q. Yes. Sponsoring institutions.
A. Yes. There are. If I can refresh my memory, there are currently 697 sponsoring institutions. And I have not been to all of them.
Q. Okay. And University Hospital is one that you have not been to?
A. Correct.
Q. Okay. You've never been asked to speak there?
A. I don't think so.
Q. Okay. Or if you had, you couldn't go?
A. Correct.
Q. Okay. The ACGME puts out an annual report --
A. That's correct.
Q. -- every fiscal year?
A. Correct.
Q. It comes out at the same time as the GME directory?
A. No. It's a little different. It comes out once a year, but the timing is a little different.
Q. Okay. And in the 2004-2005 year, a Mr. Cassimatis was the Chairman?

Page 183

A. Correct.
Q. Okay.
A. Actually, not correct. Dr. Cassimatis was the Chairman.
Q. I'm sorry. I said, "Mr.," instead of "Dr."
A. That's all right.
MR. LYONS: What are we up to?
THE REPORTER: 6.
(WHEREUPON, a certain document was marked Leach Deposition Exhibit No. 6, for identification, as of 04-20-2007.)
MR. CARLSON: I'm sorry. Would you like him to read this?
MR. LYONS: You can take a quick look at it.
BY THE WITNESS:
A. Okay.
BY MR. LYONS:
Q. You're a fast reader. You've probably seen this before.
A. I've seen this before.
Q. Okay. At the beginning of the third paragraph, Dr. -- is it Cassimatis?

Page 184

A. Yeah, Cassimatis. Yes.
Q. -- Cassimatis, okay, states that the ultimate goal of the GME is the improvement of patient care.
Do you see that? I'm paraphrasing.
A. No, I don't. I see a sentence underlined that says, "We are, of course, far from alone in our efforts to improve medical education and ultimately patient care."
Q. Okay. All right. His statement is, basically, that the ultimate goal here is the improvement of patient care; is that correct?
A. The ultimate goal is to improve medical education and ultimately patient care is what he says.
Q. Maybe I'm reading too much into this.
But the way I read it was that the ultimate goal of medical education is to improve patient care; is that fair?
A. One of the goals of medical education is to prepare physicians so that they are fully trained. And by doing that, they improve patient care.
Q. Okay. So one of the ultimate goals of

Page 185

medical education is to improve patient care?
A. To prepare physicians so that patient care will be improved, yes.
Q. Okay. You can -- oh, you did. We've got the pile there.
A. She's got the pile.
Q. You had talked at length with Mr. Martin about the work hour requirements of 80 hours per week, average, over four weeks?
MR. MARTIN: Object to form.
BY MR. LYONS:
Q. Do you recall that?
A. As part of the testimony this morning?
Q. Yeah.
A. Yes.
Q. Okay. And as I remember it, you said that in 1989, based on the Zion case, Section 405 regs were passed in New York state?
A. Yes. I did refer to the 405 regs. I didn't mention 1989. I did mention, though, the Libby Zion case.
Q. They were passed in 1989, right?
A. I don't know that. That sounds about right. Sorry.

Page 186

Q. And then, in July 1 of 2003, the ACGME -- under some legislative pressure from the gentleman/congressman you mentioned from Detroit, the ACGME passed its version of the work hour restriction?
MR. MARTIN: Actually, object to form.
BY MR. LYONS:
Q. Do you recall that?
A. The duty -- the ACGME duty hour requirements went into effect in July of 2003, correct.
Q. And -- at least, in part -- in response to some legislative pressure from Congressman Conyers?
A. In response to a variety of things that I mentioned in my earlier testimony, including the interest of Congress --
THE REPORTER: "The interest of Congress"?
BY THE WITNESS:
A. -- in doing this.
BY MR. LYONS:
Q. Now, are similar work environment restrictions placed on medical students -- particularly, third and fourth-year medical

Page 187

students?
MR. MARTIN: Object to form.
BY THE WITNESS:
A. The ACGME does not set standards for medical schools. I'm aware of some medical schools that, in fact, have medical students, on their clinical years, mimic the requirements of ACGME.
But we have no direct knowledge of whether the LCME has anything to say about duty hours. I haven't read their standards lately.
BY MR. LYONS:
Q. As far as you know, as you sit here today, though, the LCME has never published anything similar to the ACGME's 80-hour-work rule?
MR. MARTIN: Object to form.
BY THE WITNESS:
A. Correct. As far as I know, what you've said is true.
BY MR. LYONS:
Q. Do you know why that's true?
A. No.
Q. Okay. You mentioned that there's some medical schools that do restrict the third and fourth year students in their clinical work?

Page 188

A. Yes.
Q. Okay. Do you know if those are in writing, or are they just understandings?
A. I don't. And I don't have direct knowledge of that.
I've just talked to faculty members who are saying that, to prepare medical students, they function under similar local rules.
Q. Okay. And when you and I talked a month or two ago, we talked about a couple of things.
But one of the things that you had mentioned to me was that, in your view, the medical students were more observers than doers.
Do you recall that?
A. I do.
Q. That statement, as far as you're concerned today, is still true?
A. Yes.
Q. Okay. Are you familiar with an organization called COGME?
A. Somewhat, yes.
Q. It stands for what?
A. I think it's the Committee on Graduate Medical Education -- or Commission on Graduate

Page 189

Medical Education.
Q. It's a Congressionally created organization?
A. Yes, as I understand it.
Q. And it was created to advise both Congress and the Department of Health and Human Services?
A. I think that's right.
Q. Okay. Do you know who is on this council?
A. I don't.
Q. Okay. Have you ever had any contact with it yourself?
A. When I first came to ACGME, I attended, I think, two COGME meetings just to get a sense of what they do.
Q. This was in '97?
A. Probably, '98. And I have not been back.
Q. Do you have any knowledge of its reputation?
A. Not really. They issue many reports that are available for perusal by a wide audience. They are forever endangered and want to know whether they're going to be renewed by Congress or not.

Page 190

They deal with issues that we don't deal with -- like sort of manpower issues, and projections of physician supply, and so on. And we are not concerned with that.
We're only concerned with the quality of the educational program. And we don't raise or lower our standards to manipulate subsequent physicians applying.
Q. Do you have any views as to the reliability of their reports?
A. I don't.
MR. LYONS: These are excerpts.
(WHEREUPON, a certain document was marked Leach Deposition Exhibit No. 7, for identification, as of 04-20-2007.)
BY MR. LYONS:
Q. I'm assuming you've never seen this before?
A. I think I've seen the cover and didn't read the -- sorry.
Q. Like the way I read a newspaper sometimes.
DR. GENTILE: It's called looking over or

Page 191

overlooking.
BY THE WITNESS:
A. Right.
BY MR. LYONS:
Q. Anyhow, do you see the section there, on the first page, that says, "Overview."
Would you mind just reading that for a moment?
A. This is from the summary page of the Fifteenth Report --
Q. Exactly.
A. -- and of the Council On Graduate Medical Education, COGME.
"Overview: As used in this report" --
Q. No. Just read it to yourself.
A. I see. All right.
Q. Do you see it? Have you had a chance to read that?
A. I have. Thank you.
Q. Okay. In the middle of that, "Overview," paragraph, the council states -- and I quote -- "The residents, who are serving a form of apprenticeship, provide patient care under the supervision of a teaching physician."

Page 192

Do you agree with that statement of the council?
MR. MARTIN: First, I object to the form.
BY THE WITNESS:
A. The words, "provide patient care," I would want clarification on, because I think they do have direct contact with patients.
I think, for reasons previously stated, that they are not fully trained and, therefore, not able to really provide patient care services.
BY MR. LYONS:
Q. Okay. Any other comments?
A. I agree that they are under the supervision of a teaching physician.
Q. Okay. Other than those comments, are you agreeing with that statement?
A. Yes.
Q. Okay. Let me turn you over to page 5, which is the second page, actually, there.
Would you just read that to yourself? I'm sorry. Let me just focus you. The "Healthcare Provider Model," is what I'm talking about. The bottom part there I'm not concerned about.
MR. MARTIN: I'm going to object to the use of

Page 193

the document, unless you give him the full thing.
BY THE WITNESS:
A. I've read the first paragraph.
BY MR. LYONS:
Q. Could you read all the way down to where it says, "Education Model"?
A. Okay. Okay.
Q. All right. The third sentence there, at the very top, it says, "It," the current healthcare model.
This, by the way, is -- what did we say? It was 2000. Right, December 2000.
"The current healthcare model treats clinical training costs as patient care costs as opposed to educational costs?"
Do you see that?
MR. MARTIN: First of all, I object. That's not what it says. Is says, "It." It doesn't say what the antecedent to, "it," is.
BY THE WITNESS:
A. It does not say, "current model." It refers to the healthcare provider model.
BY MR. LYONS:
Q. Okay.

Page 194

A. But from this fragment, I don't even know if that's the current model in their parlance. And then it says, "It treats clinical training costs as patient care costs as opposed to educational costs."
Q. Is that part of the statement true?
MR. MARTIN: Object to form.
BY THE WITNESS:
A. I can't answer it. I don't know what, "it," is -- whether it's hypothetical or real.
And I don't know enough about the reimbursement model to know if that's true, even if it is the real current model.
BY MR. LYONS:
Q. That was where I'm going to go next.
You're not familiar with Medicare reimbursement rules?
A. Not really, only in the broadest sense.
Q. Fine.
A. From ACGME's perspective, as our standards state, we want there to be adequate financial support so that the educational program is not compromised. And the institution has to do many things to meet our requirements that require resources.

Page 195

We do not have knowledge of, nor do we care, where the source of that money comes from. We just want to make sure that there's adequate support for the educational programs.
Q. Okay. In other words, it's out of your bailiwick?
A. Correct.
Q. Now, Dr. Leach, I have noticed from your CV that you've written a lot of articles.
A. I don't know how many. Somewhere between 30 and 40, probably.
Q. That's a lot to me, because I haven't written but about one or two.
A. If you say the truth once, you don't need to say anything else.
Q. Okay. There you go.
In one of those articles, you wrote about the values in Graduate Medical Education in relation to rules, right. Do you recall that?
A. Yes.
Q. 1985?
A. I would need something to refresh my memory. But values and rules are words that I use from time to time.

Page 196

(WHEREUPON, certain documents were marked Leach Deposition Exhibit Nos. 8 & 9, for identification, as of 04-20-2007.)
BY THE WITNESS:
A. Yes.
BY MR. LYONS:
Q. Do you recognize this article?
A. I do.
Q. It was written while you were at Ford?
A. Let's see. Is it dated? The date where it says, "Posted," is blurred.
Q. I'm sorry. No. I'm sorry. My mistake.
A. I think it is later.
Q. This is 2005?
A. This was 2005. So I was at ACGME.
Q. I'm sorry. I'm thinking of another article.
Down there -- at the bottom of the first page and going up to the top of the second page -- you state that you have to pay attention to both the rules and values of medicine in physician formation.
Do you see that?
A. I do.

Page 197

Q. Physician formation is just another way of saying the GME experience?
A. No.
Q. It's broader than that?
A. It's broader. It begins in kindergarten. It is highlighted in medical school and in residency. And it goes well beyond residency. I think mature physicians are formed as well.
Q. And you also observed that values must be preserved. Rules can be modified.
A. Correct.
Q. Okay. And these values that you speak of are both with respect to the teaching hospital as well as the residency program?
A. Values include things like integrity, the ability to discern and tell the truth. So that applies to an individual as they learn how to discern and tell the truth.
It also can apply to an institution, for example, posting clinical outcomes on their Website in a way that's truthful. So that would be one example of one value that could apply to both individuals and an institution.
Q. And, I guess -- in this statement that

Page 198

you make in the context of the GME experience -- that statement could apply to both the teaching hospital as well as the individual programs; is that correct?
A. Yes.
Q. Okay. Now, are you familiar with a teaching hospital by the name of Brigham And Women's Hospital in Boston?
A. I am.
Q. It's affiliated with the Harvard Medical School?
A. Yes.
Q. A world renown teaching hospital?
A. It is an ACGME accredited teaching hospital.
Q. It's more than that; isn't it? It's one of the best in the world?
A. I think that I have -- I lack adequate knowledge to make that statement. I think I would have to know all of the hospitals in the world and compare this one. It has a very good reputation.
Q. Okay. I want to show you what I've copied off of their Website. I want to separate these here.

Page 199

A. Okay.
Q. Okay. In speaking of values for this teaching hospital, the very first one says -- and I quote -- "Quality Patient Care: Delivering quality patient care is the center of everything we do."
Do you see that?
A. I do.
Q. Okay. Would you agree that the quality of patient care is the center of everything we do at a teaching hospital?
MR. MARTIN: Object to form.
BY THE WITNESS:
A. To accept that statement, I would have to see data about the quality of patient care.
And I would have to be convinced that the quality of patient care was, in fact, better; and that it was transparent data that the public could go to the hospital and understand the quality of patient care; and that there was evidence that they were, actually, working to improve patient care.
I think this is a statement that, as I see it now, is nothing more than aspiration.
BY MR. LYONS:
Q. It's certainly an aspiration of every

Page 200

teaching hospital; isn't it?
A. True.
MR. MARTIN: Object to form.
BY THE WITNESS:
A. I think that is probably true.
BY MR. LYONS:
Q. Okay. And it certainly would be included in one of your values that you speak of in this article; is that correct, as it relates to GME experiences?
A. Correct. I think the linkage between the quality of patient care and the quality of physician formation is very real.
Q. Okay. And that's consistent with your statement, in your article there, that the rules and values have an equal place in physician formation; is that correct?
A. Yes, although they're not entirely equal -- that values are enduring and rules are ephemeral, and they're modified from time to time.
Q. But they both have a place in the GME experience?
A. Right.
Q. And this is also consistent with the fact

Page 201

that this common thread -- or one of the common threads that runs throughout the six competencies -- is patient and patient care; is that correct?
A. Correct.
Q. And to the extent that this statement by Brigham And Women's Hospital is aspirational, I think you said that that aspiration would apply equally to all teaching hospitals in this country; is that correct?
A. Correct.
Q. Okay. Now, we're going back to Henry Ford.
A. Back when I was a novice or an advanced beginner?
Q. Advanced beginner.
(WHEREUPON, a certain document was marked Leach Deposition Exhibit No. 10, for identification, as of 04-20-2007.)
BY THE WITNESS:
A. Okay. I haven't read the whole thing; but you've taken me back 21 years.
BY MR. LYONS:
Q. Yeah. That's what I was going to ask

Page 202

you.
I see down here at the bottom it was submitted for publication on October 20th, 1986. And I assume it was published on November 25th of 1986.
A. I think we're operating under the same assumptions. It was published in the Henry Ford Hospital Medical Journal, Volume 34, No. 4, 1986. I don't know what month that was.
Q. Okay. All right. I'm just trying to get a time frame here. Towards the end of '86, anyhow, it was published?
A. Right.
Q. Was this a peer reviewed article?
A. I think so. The Henry Ford Hospital Medical Journal was an in-house journal. And I actually don't know whether it ever achieved recognition by Index Medicus.
It may have. If so, it was peer reviewed. So I don't know if this particular article was peer reviewed.
Q. But probably?
A. Probably.
Q. Okay. At the very top up there, it says,

Page 203

"The direct cost of GME is estimated to be 3 billion, which includes salaries and benefits for house staff."
Okay. Do you see that?
A. I do.
Q. These salaries and benefits for house staff -- that you talk about there -- are these the payments we're talking about?
A. Correct.
Q. Okay. So you characterize them in 1986 as salaries, right?
A. When I was a novice, I called them salaries.
Q. Maybe when you didn't care what you called them?
MR. MARTIN: Object to form.
BY MR. LYONS:
Q. Okay. But, anyhow, for whatever reason, you called them salaries back in 1986?
A. Correct.
Q. Okay.
A. Correct.
Q. Now, let's go forward 12 years to 1997. Is there any reason to believe that

Page 204

things change that would make these payments other than salaries in 1997 when they were -- at least, according to you -- salaries in 1986?
A. I think, in that intervening period of time, it became more important to be clear about this issue. Because of the previously mentioned dynamics of shortened length of stays, more acutely ill and severely ill patients, more technology and knowledge, and reduced support staff, it could be tempting to some hospitals to excessively rely on residents for service.
And so it became very important to be clear that that was taboo and not, in fact, the purpose of a residency program.
Q. That did, in fact, happen, though -- that the hospitals used the residents as labor?
MR. MARTIN: I'll object to form. Are you saying all hospitals, or some hospitals, or one hospital, University Hospital?
MR. LYONS: We're talking generally now.
BY MR. LYONS:
Q. You mentioned --
A. I don't know your definition of labor. I know that one of the ACGME institutional standards

Page 205

states that the educational goals of the program and learning objectives of residents must not be compromised by excessive reliance on residents to fulfill institutional service obligations.
BY MR. LYONS:
Q. That was written when?
A. That was the reference we used earlier this morning effective September 1998, Reference Gentile 2.
And we do cite the programs. Programs that do that violate our standards. We cite them. We threaten to withdraw their accreditation if they do that.
Q. And my question to you, though, was that, during this period from '86 to '97, that there were, to your knowledge, hospitals that were using residents in performing services that sometimes had been performed by others -- other nonresident, nondoctors -- is that correct?
MR. MARTIN: Object to form.
BY THE WITNESS:
A. The only way I could answer that -- I think you're right. But the only way I could answer that with certainty is to look at how many

Page 206

institutions were cited for violating that standard.
Because if they did that, that would violate the accreditation standard.
BY MR. LYONS:
Q. But as you sit here today, with all of the vast knowledge that you have, you know that that happened, from time to time, at teaching hospitals; is that correct?
A. I know that, from time to time, we cite programs who are violating that standard.
Q. Okay. So it goes on even today then?
A. From time to time, even today we cite programs if they violate that standard.
Q. Okay. My question is, you do, in fact, cite them?
A. Yes.
Q. It happens?
A. It happens.
Q. Okay. Down in the second paragraph there, you state that -- you make four points in this article.
First, only a fraction of the additional costs of operating a teaching hospital is attributable to teaching; and elimination of the

Page 207

teaching programs will not eliminate those costs.
Do you see that?
A. Yes.
Q. Okay. Are you saying there that the GME programs only added a small fraction to the additional costs of being a teaching hospital?
A. As an example the system I was working with had a $2 billion budget. And I don't know the direct cost of the system at the time.
But it was a few to several -- probably, double digits -- millions of dollars compared to $2 billion.
Q. But as I understand what you're saying here, if you eliminate a GME program, you don't eliminate those costs. Do you see that?
A. Correct.
Q. And maybe I should ask you. What did you mean by that?
A. As stated only a fraction of the additional costs of operating a teaching hospital is attributable to teaching.
Q. Okay. The rest -- sorry.
A. And if you eliminated the teaching programs in this system that I was working in -- in

Page 208

the journal that this was published in -- saw 2-and-a-half to 3 million outpatient visits a year.
If you eliminated the residency programs, the cost of doing that would change in a minor way.
Q. Okay. Turn the page over to 264. Do you see that?
It's at the very top, the word, "Under -- under this system." Do you see that?
A. Yes.
Q. Down at the bottom of the next paragraph, "It is an act of faith," do you see that?
A. Yes.
Q. Okay. The last sentence of that paragraph says -- and I quote -- "The policy that is adopted must recognize that most of the high costs characteristic of great teaching hospitals have little to do with teaching, and that elimination of teaching programs can have little impact on reducing those costs."
Do you see that?
A. Yes.
Q. So you're suggesting that the high costs of a teaching hospital have little or no, nothing, to do with the actual teaching; is that correct?

Page 209

A. I think I'm referring to the 1983 Commonwealth Fund Report that is referenced earlier in that section.
Q. Mm-hmm.
A. That points out that large urban teaching hospitals tend to have higher costs for a variety of reasons not related to teaching.
They tend to have a higher wage index. They tend to see more indigent patients. They tend to have more advanced technology, and need to have more specialists of different types, and to have them present more often.
And those things, which are inherent in the cost of delivering patient care for that large teaching hospital, are not inherently related to teaching.
Q. I think it's -- maybe, today we could call these the indirect costs?
A. I think you probably would.
Q. Okay. Over on page 265, you highlighted down on the bottom there. It says, "Good residents." Let me just read it into the record.
A. Okay.
Q. It's a quote from your article. It's on

Page 210

the other column there.
But, anyhow, it says, "Good residents are good business for hospitals. Not only do they provide better patient care, but also improve marketing, conduct more cost-effective practice, and contribute to efficient hospital management."
Do you see that?
A. I do.
Q. Okay. That statement was true when you made it then?
A. I did write that.
Q. Was it true when you wrote it?
A. I think that --
Q. I think you can answer that, "yes," or, "no."
MR. MARTIN: Objection. If he wants to answer it, he should be allowed to answer it.
MR. LYONS: Well, he can say, "yes," or, "no," and then explain.
MR. MARTIN: Okay.
BY THE WITNESS:
A. Given my novice status, given my observations at the time, it was true.

Page 211

BY MR. LYONS:
Q. It was what?
A. True, yes, is the answer.
Q. Okay. Is it true today?
A. I think it is my observations are broader. My scope is national. I've seen a lot of things that I have not seen in 1986. And I would write a different paragraph now.
Q. The question I have, though, is, is that statement true today?
A. Not necessarily. It depends.
For example, the statement that, "Good residents are good business," I think I was referring to the fact that, if you attract talented residents, the system is helped. If you attract poor residents, the system is harmed. I think that part is still true --
Q. Today?
A. -- today. And that's true today.
I think the role of a residency program -- it has become more complex, because we know so much more about the quality of patient care. And we know about the system issues in patient care.
So I think you could have good residents

Page 212

in a dysfunctional system and actually not have it be good for patient care.
Q. How do good residents improve marketing?
A. Patients can be attracted to a system that has an explicit teaching mission.
MR. LYONS: Can we take a break for just one second?
(WHEREUPON, a recess was had.)
(WHEREUPON, Mr. Thomas Gentile left the deposition proceedings.)
(WHEREUPON, the record was read by the reporter.)
BY MR. LYONS:
Q. And teaching hospitals are not just explicit -- have an explicit, a sole, mission of teaching, right?
A. It's not a sole mission; but it needs to be an explicit mission.
Q. Okay. Obviously, they have a patient care mission as well?
A. Right.
Q. Okay. And from an economic perspective, that's the great majority of where the revenue is generated is from their patient care?

Page 213

MR. MARTIN: Objection. Form.
BY MR. LYONS:
Q. That was a, "yes"?
A. Yes.
Q. Okay. One thing that I did forget to ask you. I asked you about the validity of that one statement that I read into the record today. And you indicated that you'd probably write it a little differently.
What about 1997, which was 11 years later? Would you have changed it at that point?
A. I think -- and, again, this is my memory from 21 years ago. I think the point that I was trying to make is that, if you attract a good resident as opposed to a bad resident -- i.e., if your educational program is attractive to the very best medical students so they come to your program -- good things happen throughout the system, because you've got talented people there.
If you've got a poor educational program and attract poor medical students, bad things happen to your system, because you have not gotten talented people there.
Q. Hard to market?

Page 214

A. So, for example, you mentioned marketing. And I would have used a different word for that.
But if a resident -- who is very smart and very bright -- is sitting with a patient, getting a history, and examining the patient, the patient feels good because it's obvious this person is bright and attentive.
If you've got somebody who is stupid and doing that, the patient is not as competent in the system. And so I think that was the point I was trying to make.
Q. Okay. What is the exhibit number on that one?
A. Exhibit 10, Leach 10.
Q. Okay. We'll bring you up to -- a little closer to current events here.
MR. LYONS: There's one for you and one for him.
(WHEREUPON, a certain document was marked Leach Deposition Exhibit No. 11, for identification, as of 04-20-2007.)
BY MR. LYONS:
Q. This is an article that you wrote, in

Page 215

December of 2000, for the academic medicine?
A. Yes.
Q. Is that a journal, a magazine?
A. It's a journal.
Q. Okay.
A. It's a peer reviewed publication from the Association of American Medical Colleges.
Q. And this is a peer reviewed article?
A. Yes.
Q. Okay. And at this point in your career, you're beyond that early stage where you might regret some of the things you might have said?
A. Oh, never.
Q. I thought you never made a mistake. Okay. All right.
Anyhow, over on the second page of this 2000 article -- right at the top of the page there -- it says, "These behaviors," which, I believe, is working too long. Is that what you have reference to there?
A. I was referencing the program requirements in surgery which -- and the language is graduate education in surgery requires a commitment to continuity of patient care.

Page 216

"The continuity of care must take precedence without regard to the time of day, the day of the week, the number of hours already worked, or on-call schedules. At the same time, patients have a right to expect a healthy, alert, responsible, responsive physician dedicated to delivering affective and appropriate care.
The program director must establish an environment that is optimal for both resident education and for patient care while ensuring that undo stress and fatigue among residents is avoided. It is his or her responsible to ensure assignment of appropriate in-hospital duty hours so that the residents are not required to perform excessively difficult or prolonged" --
Q. I'd hate to interrupt you. But I don't want you to read this whole thing into the record, unless you feel it necessary. But certainly not for me.
A. All right. "These behaviors," and then you're suggesting --
Q. Maybe just read it to yourself.
A. Okay. I was trying to answer your question.

Page 217

Q. Yeah.
A. And the reference is in 1999. The Surgery Residents Review Committee reviewed 69 surgery programs and cited 36 of those programs.
And so the behaviors are a violation of these requirements and not just working too long?
Q. Okay.
A. That's my point.
Q. Okay. That's fine. But it included working too long, but others as well?
A. Right.
Q. Okay. But at any rate these behaviors may reflect a lack of clarity about the purposes of Graduate Medical Education.
And then you state, "I would propose that the overriding purpose of GME is to improve patient care." Do you see that?
A. Yes.
Q. So your view, in the year 2000, was that the overriding purpose of GME is to improve patient care; is that correct?
A. By creating a fully trained physician workforce.
Q. Okay. And just so that we're clear, that

Page 218

statement that you believe the overriding purpose of the GME is to improve patient care -- while it was made in the year 2000 -- that certainly would have been applicable in 2004 as well, right?
A. Yes.
Q. Okay. Now, in connection with this article, just generally, one of your points -- it looks like to me -- is that, once again, that one of the ways in which this learning experience takes place is through patient care; is that correct?
A. That's correct.
Q. Okay. And this patient care, if you will, is done in ever increasing increments, in terms of the complexity of the procedures, as one goes through the training program; is that correct?
A. Correct.
Q. Okay. Now, at some point during a particular resident's program, there comes a time when they have done these procedures a sufficient number of times and successfully where they can, in fact, be credentialed for that particular procedure in a hospital; is that correct?
A. There's two parts to your question. The credentialing for that procedure, at the particular

Page 219

hospital, may have other requirements -- such as graduating from an ACGME-accredited program -- before they can be credentialed for anything.
Q. Okay.
A. Also, I think the number of procedures is only one element of the part -- for example, the Surgery Residents Review Committee limits the numbers of procedures -- as well as requires a minimum -- to make sure that the resident is not being unduly relied upon to provide patient care.
And so the quality of the experience, as well as the number of times people have participated in it, are important.
Q. You were aware, though, that there are some programs who will allow their residents to perform a particular procedure, or who will credential a resident for a particular procedure, if he is qualified to do that procedure prior to the time he leaves the residency program.
You're aware of those situations?
A. I can think of things like starting IVs and things like that once you've done it a certain amount of time. Some hospitals have credentialed residents do things like that.

Page 220

Q. And that would be in an unsupervised setting, right?
A. No. There's always supervision in the setting. The level of supervision varies depending on the experience of the resident.
Q. Okay.
A. So, for example, in the early period, you are inches away from someone who knows what they're doing.
And as you get more advanced in your training, you're still supervised by them; but they may not be inches away from you anymore.
Q. A phone call away?
A. Sometimes a phone call away, sometimes in the operating room and scrubbed, but not participating directly.
Q. My point is that sometimes the attending may not be physically present; is that correct?
A. Correct.
Q. Okay.
A. It depends on the specialty, and it depends on the circumstances.
Q. Okay.
A. But the resident is always supervised.

Page 221

Q. Okay. Let me take it to one step further.
In the fellowship situation, which you had talked with Mr. Martin about, the fellow is typically a -- no, "typically" -- but almost always is an individual who has got a completion certificate from a specialty, correct?
A. Usually. Sometimes they have not yet taken the examination. They're eligible for it and frequently have achieved certification in the primary specialty, yes.
Q. But in order to get accepted into a fellowship, you, first of all, have to have completed some, quote, "specialty residency program"?
A. Yes.
Q. Okay. So that would mean, then, that a lot of fellows could, in fact, be board certified by the time they begin the fellowship?
A. Correct.
Q. They also could, under the ACGME rules, moonlight, right?
A. Moonlighting exists. We have a lot of cautions about it. And many programs prohibit it.

Page 222

We feel the educational program is a full-time duty. And so we require that the program director approve all moonlighting. We prohibit it ever from being mandated. You cannot have mandatory moonlighting.
Any moonlighting that is done in-house must count for the resident duty hour regulations. So we recognize the phenomenon. We put constraints around it. But you're right. It does happen.
Q. And so I'm clear, the ACGME does not specifically prohibit it?
A. No. We constrain it.
Q. Okay.
A. We prohibit mandatory moonlighting.
Q. Fine. And so that would mean, in the case of a fellow who is board certified and licensed, he could use some of his fellowship time -- if he so chose and was approved -- to go out and practice medicine unsupervised?
A. He could. That's correct. He could practice medicine.
He could not -- for example, if he is a cardiology fellow, he could not practice cardiology. But he could practice general internal medicine.

Page 223

Q. And, in fact, that happens quite often to fellows; doesn't it?
A. It happens. We actually don't know how often it happens. It's impossible to monitor.
Q. Does the ACGME have an interest in trying to monitor it, or has it just given up?
A. No.
MR. MARTIN: Object to the form.
BY MR. LYONS:
Q. You can answer it.
A. We do monitor it if it occurs in the teaching hospital. And we require that it be monitored so that it comes under the constraints of our duty hours.
But it is a free world. And if you leave that hospital, and go to a nonteaching hospital, and work in an emergency room, we have no way of knowing whether that's happening.
Q. Even though you have to get approval, before you do it, from the program director?
A. Correct.
Q. They may have the records, but you don't?
A. Correct. When we do a site visit, we ask to see those approval mechanisms. And they're in

Page 224

place or we cite them.
But we don't know that Resident "A" worked one Saturday a month, and Resident "B" worked two Sundays a month, or something like that.
Q. Okay. While we're on this work hour situation, let me go to the other end of the spectrum.
Are you aware of any residency programs where the resident would work less than 40 hours a week?
MR. MARTIN: Object to the form.
BY THE WITNESS:
A. I would not use the word, "work."
BY MR. LYONS:
Q. All right.
A. For all of the reasons stated, we used the word, "duty." In fact, in your reference to the much earlier institutional requirements where language like, "employment," and, "work," exist, we have now modified our language, in more recent requirements, to make sure we're absolutely clear about our position on this.
So using the word, "duty," there are residency programs where the duty typically is the

Page 225

order of magnitude you've suggested, 40 hours or so.
Q. Are you aware of any that are less than 40?
A. I think that residencies vary by the nature. So, for example, in a dermatology residency -- which tends to be a daytime practice, not a heavy in-patient load -- it's quite possible to have direct patient contact during half-day sessions five days a week, or something like that, and have other didactic sessions or other sessions in pathology.
And it's conceivable you'd be in the realm of 40. I can't answer whether there's --
Q. 31 or --
A. -- 39, or this one is 38, or something like that.
Q. Okay. But by and large, most of the programs are in excess of 40?
A. Correct.
Q. Okay.
A. I think our resident duty hour survey would suggest that on average most programs are around 60 hours of duty.
Q. Yeah. There's a couple of them close to

Page 226

80. But you're right on average. I think you're probably about right.
A. Yes.
Q. Once again, this duty hour/work hour, whatever you want to call it --
A. Duty hours.
Q. We'll call it duty hours, fine. We have a work environment. We have duty hours. Okay.
MR. MARTIN: I move to strike.
BY THE WITNESS:
A. We no longer have a work environment.
BY MR. LYONS:
Q. Okay. I'm talking about the ACGME Essentials --
A. Yeah, right.
Q. -- that were in play during our period.
A. Right.
Q. The words, "work environment," was used, right?
A. In the 1998 requirements, the word, "work environment," was used, correct -- words.
Q. In 1999 and 2000?
A. I think that's right.
Q. Okay.

Page 227

A. I would have to check. It is no longer used.
Q. Okay. Do you know when it went out?
A. I don't. I would have to refresh my memory by looking at every year sequentially.
Q. Okay. Whether it was before or after 2004, you're just not sure?
A. It was before 2004. It was out by July of 2003. I don't know when before then it went out.
Q. Okay. But it had been used in the past?
A. Correct.
(WHEREUPON, a brief interruption was had.)
MR. MARTIN: Excuse me. Can I have your indulgence?
MR. LYONS: Sure.
(WHEREUPON, a recess was had.)
BY MR. LYONS:
Q. Well, let me go back.
Anyhow, during this period of time -- maybe not for every year -- the ACGME used the terms "duty hour, work hours, work environment."
We're all in agreement on that, right?
A. Yes.

Page 228

Q. Do you know whether the ACGME ever put in writing anything about -- with respect to their accredited programs -- anything that referred to educational hours?
Specifically, has that ever been written before as far as you know?
A. It may have. It would require reviewing the 300 pages into the curricular elements. There are statements about the frequency of various conferences, the frequency of rounding of different types -- including educational rounds.
So it's possible that language exists.
Q. But as you sit here today, without going through all of this, you can't point me to anything that uses the specific term, "educational hours"?
A. Let me stall as I look through the medicine program requirements.
Well, for example, again, I have not done a thorough review. But teaching rounds must occur, at least, for a minimum total of 4.5 hours per week.
There's a particular subsection of educational activities known as teaching rounds; and it has to be 4.5 hours a week. It does not say, "educational hours."

Page 229

Q. That's what I'm asking.
A. Right.
Q. Okay. In your conversation with Mr. Martin, you had talked about some of the reasons why residents go into residency programs.
One of those reasons -- I'm not sure you mentioned it. I don't think you did. But one of those reasons would be so that they can become board certified. Would that be correct?
A. That's correct.
Q. Okay. And you also indicated that you didn't believe that a resident went into a residency program to get a big salary?
A. Yeah. Correct.
Q. Okay. But what they do do is, they make an investment in themselves so three years later they can get a big salary; is that right?
A. They make the investment so they can practice independently. Once graduated and practicing independently, the salary ranges are quite extreme.
And some physicians make a big salary and some physicians make a modest salary; and, yet, the various specialties attract residents preparing for

Page 230

all of those possibilities.
So I'm not -- I don't think you enter a residency in order to make a big salary a few years down the road. If you were doing that, the lower reimbursed specialties would not attract residents, and they do.
Q. But by accepting a lower -- or accepting a low -- I think the term is, "low salary," you are, in effect, investing in your future; is that correct?
A. Correct.
Q. Okay. Thank you.
MR. MARTIN: Objection. I don't think he used the word, "salary," in his prior testimony.
MR. LYONS: In 1986 he did.
MR. MARTIN: Okay. But you were referring to his earlier testimony, at that point, when you used the phrase, "salary."
MR. LYONS: I don't care.
BY MR. LYONS:
Q. Would you mind pulling out Exhibit 2. Turn over to page 25.
By the way, this is the 1999-2000 Essentials; is that correct?

Page 231

A. That's correct.
Q. Okay. Under B there, it says -- the second sentence says -- "GME focuses on the development of clinical skills and professional competencies and on the acquisition of detailed factual knowledge in a medical specialty."
Do you see that?
A. I do.
Q. And under this paradigm, the resident gains, progressively, skills in competency and knowledge as he goes through the residency program; is that correct?
A. Correct.
Q. Okay. Doesn't this, in many ways, describe what goes on in any work environment -- particularly, a highly skilled work environment?
A. And it includes the life-long learning of physicians after they graduate from ACGME accredited residency programs.
Q. So your answer is, "yes"?
A. Yes, in the sense that it is inherent in any educational process, regardless of where along the continuum, that you are developing skills and competencies.

Page 232

Q. Now, in our discussions of the focus of the ACGME, its focus is primarily on the resident and the residency programs; is that right?
A. Its focus is on the residency program, yeah, residency programs and the sponsoring institution.
Q. And the relationship the resident has to the residency program?
A. Our standards are program standards. They're not resident standards.
But they do get into the relationship between the program and the resident, yes.
Q. So, obviously, the central player in all of this is the resident, right?
A. Yes.
Q. Okay. And the institutional requirements and the program requirements are primarily directed to the GME program, itself, as opposed to, say, imposing requirements on the teaching hospital, for example?
A. The institutional requirements are focused on the administrative support for all educational programs.
And that does include putting a large

Page 233

number of requirements on whoever the sponsor is. If the sponsor is a teaching hospital, it puts those requirements on the hospital.
Q. And those requirements are related to making sure that it complies with the program requirements that are required of the residency program; is that correct?
A. That's one element of it. And then there are other elements -- like the duties of the Graduate Medical Education Committee -- that are not directly related to the program requirements.
Q. The sponsoring organizations also must have these contracts with certain things in them, right?
A. The residency program has a -- the institution creates the agreement. And we hold the details of that agreement. We hold them accountable for the details of the agreement as specified in our institutional requirements. And then it varies.
In some places the agreement is between the resident and the institution; and in other places it's between the program and the resident.
Q. But just so that I'm clear on what the ACGME believes the main focus here is, is it that

Page 234

the main focus here is on the training of the resident; is that correct?
A. Correct.
Q. And in conjunction with that focus, it, for example, requires these teaching hospitals to make certain physical facilities available.
It requires them to have contracts with the particular residents?
A. Correct.
Q. Okay. The ACGME does not focus, in any way, for example, on how the hospital should operate?
A. Correct. Other than we do require that the hospital demonstrate quality patient care as measured by JACO or other entities that accredit the quality of patient care.
Q. But other than that, the requirements of the ACGME don't deal with the operation, itself, of the hospital?
A. Correct.
Q. Its focus is on the residency program and the residents?
A. Correct.
Q. Okay. Excuse my voice.

Page 235

It seemed to me, in listening to your conversation with Mr. Martin this morning, that one thing was for certain.
And that is that accreditation of a particular program depends solely on meeting minimum standards of the ACGME; is that correct?
A. That's correct.
Q. So that's what it means to be accredited? It is that you have met the certain minimum standards?
A. Correct.
(WHEREUPON, a certain document was marked Leach Deposition Exhibit No. 12, for identification, as of 04-20-2007.)
BY MR. LYONS:
Q. Okay. Have you seen this before?
A. I have.
Q. Okay. Did you review it?
A. I saw it once. It was posted on the Website, I think.
Q. You didn't have anything to do with drafting it?
A. Not directly, no.

Page 236

Q. Did you ever review it before it was published?
A. I don't know that I did. Susan Swing is the Director of Research and Education for the ACGME. Christine Taylor was a summer student who worked with her to develop this. And they did it and posted it on the Website.
And I saw it then. But I can't remember whether -- it wasn't presented to me for approval or anything. But Susan Swing works for me, so...
Q. Okay. At the time that you read it, was there anything in there that you thought was incorrect, inaccurate?
A. I don't think so.
Q. Okay. By the way, "Outcome Project," is this a project in connection with the six competencies?
A. Yes. In September of 1997, the ACGME committed to using Educational Outcomes as an accreditation tool.
That commitment is expressed in this long-term outcome project of which the competencies are derivative.
Q. Okay. And this was published, I

Page 237

believe -- let me see if there is a date on this.
Do you have a date? Maybe you could help me out as to about when it would have been published.
A. I think Christine Taylor worked with Susan, maybe, around 2004, in that range. And this work would have been --
Q. Right around that time?
A. Right.
Q. So probably towards the end of the period we're talking about in this case?
A. Correct.
Q. Okay. Turn over to -- well, the only marking on it is 033-1495.
A. Okay.
Q. It's got a paragraph 3 there.
A. Yes.
Q. And then it's got two bullet points.
A. Yes.
Q. The first bullet point says -- and I quote -- "Much of residency education occurs as residents are performing patient care activities in the same setting where professional practice will occur."

Page 238

Do you see that?
A. Yes.
Q. Is that an accurate statement?
A. Yes.
Q. Okay. Then in the very next bullet point there, they point out -- I'll quote -- "Learning opportunities provided through lectures, conferences, and independent reading are not as close to, quote, 'real life,' close quote, as the experiential learning that takes place in the clinical setting."
Do you see that?
A. I do.
Q. Okay. Do you agree with that statement?
A. I do.
Q. Okay. Putting it into plain English, would it be fair to say that, while didactic training is necessary, that, in order to get the real experience of a GME, you need to get into the clinical setting.
Would that be fair?
A. I agree.
Q. Okay. And since this was written at the end of our period, would these statements that we

Page 239

just talked about here -- these two bullet points -- would they be applicable as well for the years 1997 through 2003?
A. Yes.
Q. Okay.
(WHEREUPON, a certain document was marked Leach Deposition Exhibit No. 13, for identification, as of 04-20-2007.)
BY MR. LYONS:
Q. Have you seen that before, Exhibit 13?
A. It's a Power-Point slide on an ACGME template. It may be part of a Power-Point presentation under the "Outcomes Project" section of the ACGME Website. But I'm not certain.
Q. I think that you're absolutely correct. That's, at least, the way it was given to us by Mr. Martin. That appeared to be the case. This came out of some documents that he produced to us.
At any rate, what I'm most interested in is what it says here. And this is a summary of what the ACGME feels is the best way to implement the six competencies?
A. It's part of a -- the slide is entitled,

Page 240

"Summary." I think that implementing the six competencies is much more complex than this, but this is part of a summary.
Q. Okay. And it says here that they list two major goals. One, "Develop competence as a physician," and, two, "Improve patient care." Is that true?
A. Correct. It says, "The major goals of the Outcome Project are: One, develop competence as a physician, and, two, improve patient care."
Q. And the, "Outcome Project," is how do we implement the six competencies?
A. How do we use educational outcomes as an accreditation tool and, as part of that, deconstructing physician competence into six competencies and measuring and improving those competencies.
So this goal would be served by assessing and advancing the quality of resident education through accreditation and through these competencies. The goal is to improve the preparation of physicians and, thereby, improve patient care.
Q. You use the word, "preparation." She

Page 241

used -- or somebody used the word, "competence." I guess they're interchangeable.
A. We do not think of a physician as competent until they've completed residency. And I think these are compatible statements.
"Develop competence as a physician; i.e., residents upon graduation are competent. And, thereby, because their training has been improved, patient care will be improved when they go into practice."
Q. And I think your last statement there to me really reflects the interrelationship between the patient care and what the program requirements are; is that correct?
A. Yes. I think that's correct.
Q. Okay.
A. Through our activities, we improve patient care by assessing and advancing the quality of resident education through accreditation.
Q. And that improvement process along the way, if you will, takes place -- at least, in part -- through the patient care that we talked about; is that correct?
A. Correct. Correct.

Page 242

(WHEREUPON, a certain document was marked Leach Deposition Exhibit No. 14, for identification, as of 04-20-2007.)
BY MR. LYONS:
Q. Before you read that article, let me just ask you a couple of preliminary questions.
Is the New England Journal of Medicine a peer-reviewed journal?
A. It is.
Q. So the articles that would appear in there would be peer reviewed?
A. Correct.
Q. It's a well-respected medical journal?
A. Opinion varies; but, in general, that's true.
Q. Okay. Have you ever seen what's been marked as Exhibit 14?
A. I saw it in the journal, itself. It has a little different form now. I assume the words are the same.
Q. This is the way it was given to us.
A. Right.
Q. Have you read this article before?

Page 243

A. I have some time ago; but I have read it before, yes.
Q. Okay. Let me just direct you to a couple of the passages I want to talk about. On the first one, it would be page 34-0003.
A. Okay.
Q. Okay. By the way, are you familiar with any of the physicians who wrote -- well, they're not all physicians -- but the physicians who wrote this article? I guess, all but two of them are.
A. I know Molly Cooke. I know Dave Irby. I know Ken Ludmerer. I know of -- but don't know -- William Sullivan.
Q. Well-respected in their fields?
A. Yes.
Q. Okay. Over there on page 3, under the third paragraph, in that, "Learning Medicine as Professional Education," do you see that?
A. I do.
Q. It starts off with, "Responsibility." Do you see that?
A. I do.
Q. It says -- and I quote -- "Responsibility for the care of patients is a powerful stimulus for

Page 244

learning." Do you see that?
A. I do.
Q. Okay. Do you agree with that statement?
A. Yes. I interpret it as anticipating the day when I will be independently responsible for care of patients.
And knowing what a heavy burden that is, I really would like to learn how to take care of patients.
Q. And as we've said so many times, one way that you learn how to do that is through patient care?
A. Right.
Q. As a matter of fact, that statement has probably been true through the inception of residency programs; isn't it?
A. And before.
Q. And before. Okay. Later on, in that same paragraph, the authors state -- and I quote -- "Given that every patient deserves the best possible care, we are challenged to provide appropriate opportunities for experiential learning and practice while meeting the service demands of teaching hospitals."

Page 245

Do you see that?
A. I do.
Q. Okay. Do you believe that statement to be true?
A. Yes. Just to be clear, this is experience -- "experiential learning," not experimental learning.
Q. Did I mispronounce it?
A. I think you said, "experiential," but there was a little stumble. And I just want to make sure it's recorded.
Q. Okay. All right. But with that little change?
A. Right.
Q. Okay. So if I understand all of this, it's that the service demands with a teaching hospital have to be taken into consideration in developing any GME program; is that what they're saying?
MR. MARTIN: Object to form.
BY THE WITNESS:
A. I do not interpret it that way. Given that every patient deserves the best possible care, we are challenged to provide appropriate

Page 246

opportunities for experiential learning and practice while meeting the service demands of teaching hospitals. And the sentence is unclear, because I haven't pulled it out of context, whether it refers to the faculty. I assume it does.
So I assume this is a sentence about the needs of the faculty to see patients and the needs of the faculty to be present and teach residents. And parsing out their time may be challenging. That's one possible interpretation of this.
BY MR. LYONS:
Q. There is a balancing act between the service needs of the hospital and the experiential --
A. Right. Correct.
Q. -- learning and practice --
A. Correct.
Q. -- of the residents?
A. Right.
Q. Okay. Well, that's how I read it, too.
Over on -- let me see. Okay. Let's see. On page 04 -- the second paragraph in, "Preparing Physicians for the 21st Century" -- the second paragraph there, would you mind just reading that to

Page 247

yourself.
A. Just to be clear, "The acquisition of skills"?
Q. Yeah. Yeah. I'm sorry.
A. Okay. Okay.
Q. Okay. Is what they are stating here -- and, perhaps, it's stated much more succinctly by yourself and the testimony here today.
But is really what they're saying here is that the essence of a successful residency program, and the challenges of a successful residency program, is to provide residents an environment where they can learn how to provide good patient care without putting patients at risk in service to education? Would that be fair?
MR. MARTIN: Objection to form.
BY THE WITNESS:
A. Yes.
BY MR. LYONS:
Q. Okay.
A. I think. And toward the end of the paragraph, it references simulation and other opportunities to practice skills remote from direct patient care.

Page 248

Q. But my summary of that is accurate in your view?
A. Yes.
MR. MARTIN: Of what the authors are saying?
MR. LYONS: No. No. My summary of what the author is saying.
BY MR. LYONS:
Q. And I think your -- I think, Doctor, if I heard you correctly, that you agreed with what I said. Did I hear that correctly?
MR. CARLSON: We're sufficiently removed in time. Perhaps, the reporter might repeat it.
(WHEREUPON, the record was read by the reporter.)
BY THE WITNESS:
A. So there was a little -- I heard you say, "without putting patients at risk in service of education."
BY MR. LYONS:
Q. Yes.
A. And she read, "without putting patients at risk and service of education."

Page 249

So I would agree with your statement using, "in," in that paragraph.
Q. Okay.
A. Okay.
Q. And that's what I did say.
A. Right.
Q. Over on page 05, "Finding the Will to Change."
A. Yes.
Q. Okay. And the second paragraph there starts, "Reform of the process"?
A. Yes.
Q. Okay. Then, in the third sentence there, they say, "Long-term preceptorships or apprenticeships are being reestablished to ensure adequate observation, supervision, and mentoring of trainees."
Do you see that?
A. I do.
Q. He indicates that preceptorships or apprenticeships are being reestablished.
Had, at some point in time, they gone out and come back? Is that what he's referring to?
A. No. I think the sentence refers to

Page 250

medical students rather than residents.
So the previous sentence says, "Some schools are developing clerkships that no longer focus solely on departmental inpatient services, but instead include interdisciplinary approaches to the teaching of inpatient and outpatient care. Long-term preceptorships or apprenticeships are being established."
So, in other words, typically, a medical-student rotation is a sequence of experiences that are disconnected. And they claim that some medical schools are establishing long-term preceptor or apprentice relationships with a mentor that cut through the various rotations through medical school.
Q. The reason I thought, perhaps, he referred to residencies is, he used the word, "trainees." And I've never heard that word used in reference to medical students.
A. Given the previous sentence, I would interpret it as referring to medical students.
Q. Okay. Okay. You had mentioned earlier, I believe, the Commonwealth Fund?
A. Yes.

Page 251

Q. A 1982 report, I believe?
A. Yes.
Q. Okay. What is the Commonwealth Fund?
A. I don't really know. I think it's a foundation. And it commissions studies done on various phenomena in society that go beyond medicine, but also include medicine.
Q. Okay. Are you familiar with the report of the Commonwealth Fund Task Force on Academic Health Centers in April of 2002?
A. I know of it. I don't know it. So I can't say I'm familiar with it. But I know of it.
Q. Well, let's see if we can explore that a little bit.
(WHEREUPON, a certain document was marked Leach Deposition Exhibit No. 15, for identification, as of 04-20-2007.)
BY MR. LYONS:
Q. Have you seen this report before?
A. Not really. I've seen the title and the document, but I haven't really read it in detail.
Q. Okay. Let me see if we can go through this and make some sense out of it.

Page 252

It's a document that was produced to us by Mr. Martin.
MR. MARTIN: Excuse me. But didn't I produce the whole document, and you've only produced part of it?
MR. LYONS: It was about 400 pages, as I recall.
MR. MARTIN: Okay.
MR. LYONS: That's why we didn't copy the whole thing. I'm not going to ask him about the other --
MR. MARTIN: I would object to questions, unless you give him the whole document.
MR. LYONS: That's fine.
BY MR. LYONS:
Q. Anyhow, on page what's Bates Stamped 15 --
A. Yes.
Q. -- down there at the bottom, under, "Findings" --
A. Yes.
Q. -- would you mind just reading that paragraph, the introduction, and then the first four.

Page 253

MR. CARLSON: To himself?
MR. LYONS: Yeah. Just to himself.
MR. CARLSON: Okay.
BY THE WITNESS:
A. Okay.
BY MR. LYONS:
Q. Okay. First of all, "AHC," is Academic Health Center?
A. Yes.
Q. Okay. The fourth finding there says -- and I quote -- "The clinical environment within AHCs is widely perceived as unresponsive to medical education."
Do you see that?
A. It's, "unreceptive," I think.
Q. What did I say?
A. "Unresponsive."
Q. You're right, "unreceptive." I stand corrected. Thank you.
Now, an academic health center is what?
A. They define it, I think, as medical schools and their closely affiliated hospitals and physician groups in Paragraph 1.
Q. Yes. Okay. And that would include

Page 254

things like teaching hospitals?
A. Yes.
Q. Okay. Now, they're finding there that the clinical environment -- within these academic health centers -- is widely perceived as unreceptive to medical education.
Do you hold that same perception?
A. There have been challenges as the clinical delivery patterns have changed.
So, for example, as mentioned earlier, the hospital length of stays have shortened and the patients in the hospital tend to be very sick and of a particular type.
A lot of patient care has shifted to various ambulatory sites.
Q. By that, you mean, like, clinics?
A. Like clinics.
Q. Okay.
A. And there the time is even more constrained. So patients, if they're in the hospital for two weeks, may be willing to have medical students and residents sit and talk with them.
They're less willing if the parking meter

Page 255

is ticking and they've got to be somewhere else in a half an hour. So the interface between the clinical delivery system and the educational mission is more challenged now than it used to be.
Q. Perhaps, even disconnected somewhat?
A. No. I don't think it's disconnected. And I would disagree with the word, "unreceptive." I think it's more of a challenge that academic health centers are trying to wrestle with.
Q. But there is this problem out there?
A. Correct.
Q. Here is another part of the report.
(WHEREUPON, a certain document was marked Leach Deposition Exhibit No. 16, for identification, as of 04-20-2007.)
BY MR. LYONS:
Q. This is just some more pages that fall right behind the previous page.
MR. CARLSON: It's from the same document?
MR. LYONS: The same document, yeah. I just split them up.
BY THE WITNESS:
A. Okay.

Page 256

BY MR. LYONS:
Q. Okay. Turn to that last page, which is page 24. By the way, this report was in April of 2002, I believe, right?
A. The title page is dated April of 2002.
Q. Okay.
MR. MARTIN: I'd have the same objection, unless you give him the rest of the report.
MR. LYONS: Okay.
MR. CARLSON: I'm sorry. Are you asking him to focus on a particular element?
BY MR. LYONS:
Q. Yeah. The last paragraph on page 24. Just read it to yourself, if you don't mind.
A. Okay.
Q. Okay. In that paragraph, the authors state that there's been a dramatic increase in the number of residents over the last four years, and that there have been any reasons for that increase. One of which was the reliance of hospitals on residents as a source of labor.
Do you see that?
MR. MARTIN: Object to form.
BY THE WITNESS:

Page 257

Q. First, I think you said, "four years," and the article says, "forty years."
BY MR. LYONS:
Q. I meant to say, "forty."
A. Right. And then there is, in the second sentence, "Among the many reasons for this growth are the growth in the UME enterprise, the increasing complexity of medical care requiring longer periods of medical training, the increased reliance of hospitals on residents as a source of labor, Medicare program incentives that encourage hospitals to increase the size of GME programs, the lack of a single national organization with the power to control the overall size of the GME enterprise, and an influx of graduates from foreign medical schools to U.S. residency programs."
Q. The question I had for you was that, out of the many reasons why -- over the last forty years -- the GME programs have expanded -- maybe expediently -- one of the reasons was the increased reliance of hospitals on residents as a source of labor?
MR. MARTIN: Are you asking if that's true or if that's what the article said?

Page 258

BY MR. LYONS:
Q. The first question I have for you is, that's what the article says, correct?
A. That is what the article says.
Q. Okay. Do you agree with that statement?
A. No, I don't.
Q. Why is that?
A. Because it's not true.
Q. Well, tell me why it's not true.
A. Residents are not a source of labor. They're students, and they're in an organized educational program.
Even if you considered them a source of labor, they're an inefficient source of labor. They are not fully trained. It would be very dangerous to have them function in that capacity. So I don't agree with that at all.
Q. Of course, if the labor that they're talking about is something other than performing services as a doctor -- for example, at some lower level, less skilled -- that they might be competent to do, right?
A. Not really. For example, we have standards that hospitals have to have phlebotomists,

Page 259

and IV teams -- and other things that involve labor -- taking care of patients.
And once you've seen a resident sort of muck around trying to get an IV started and compared that to an IV tech who can do it blindfolded, you would never go back and use that resident as a source of labor.
Q. How about pushing a patient down a hallway on a stretcher?
A. We also have standards that require the sponsoring institution to have transportation services and messenger services for the same reason -- that residents are not a good source of labor even for these tasks. That's not their function.
Q. You've never heard anecdotal stories that it happens?
A. I've been training and pushed all kinds of carts around all kinds of places. But the ACGME has now required standards that prohibit that. And they've done it to preserve the primary educational mission of residents.
Q. Saying not to do it and not doing it are two different things, now, right?

Page 260

A. Well, we monitor for it. And if we detect it, we cite programs for that.
Q. Okay. Fair enough.
Are you familiar with a group called The Blue Ridge Academic Health Group?
A. Not directly. I've heard of them. But I don't know who they are or what they actually do.
Q. Have you ever read anything they've written?
A. No. I've heard they've produced a report, but I have not read it.
Q. Okay. We'll give you the opportunity.
A. Thank you.
MR. LYONS: 17?
THE REPORTER: Yes.
(WHEREUPON, a certain document was marked Leach Deposition Exhibit No. 17, for identification, as of 04-20-2007.)
MR. MARTIN: Is this the entire report, do you know, Steve?
MR. LYONS: I don't know.
BY THE WITNESS:
A. The index goes through to page 28, and

Page 261

the document goes through page 13.
MR. LYONS: No, it's not.
MR. MARTIN: I would object to the use of the document, unless you give him the full document -- particularly, since he hasn't seen it before.
BY MR. LYONS:
Q. You said you had not seen this document before?
A. Correct.
Q. Okay. I want to direct your attention to page 95, which is page 8 of the report.
A. Yes.
Q. Over on the left hand column, the second paragraph starting with the UME.
A. Yes.
Q. "UME," is Undergraduate Medical Education?
A. Correct.
Q. Just read that.
A. To myself?
Q. Yeah, please.
A. Okay.
Q. They state in there that -- and I quote -- "The many years of clinical exposure and

Page 262

training, from internship through residency and fellowship, are taught and supervised largely by faculty and residents who have little or no formal training or skill development as educators."
Do you see that?
A. I do.
Q. Do you agree with that statement?
A. Underline, "formal training," yes. They don't -- they're not graduates. They don't have degrees of education.
They are physicians, and they do teach by habit. But they have not had formal training as a rule in education.
Q. Okay. So with that caveat or that qualification, then, you would agree with that statement?
A. Right.
Q. Okay. On that same page -- and, by the way, this article was written in May of 2003; is that correct?
A. That's the date on the title page.
Q. Okay. Just read to yourself that last sentence right before the topic, "The New Medical Marketplace."

Page 263

A. Okay.
Q. Do you agree with that statement?
A. Yes. It's a metaphor using a magnetic pole as an attractor. And board certification is a major milestone that concludes the Graduate Medical Education Phase of physician training. And so it is a goal.
Q. If I could be so bold, what it means to me, I think, is that board certification is one of the major reasons why you would go through undergraduate and postgraduate medicine?
MR. MARTIN: Object to form.
BY THE WITNESS:
A. Board certification is one of the elements needed to practice independently in most hospitals. Most hospital credentialing committees look for that.
And so, again, that's one of the elements -- along with licensure and credentialing -- that enables you to practice independently, all three of which require graduation from an ACGME-accredited program.
BY MR. LYONS:
Q. We kind of left out the osteopaths in

Page 264

this equation; haven't we?
A. Right. There is a council on postgraduate -- they call it postgraduate education just to be confusing. That's a Council on Postgraduate Medical Education developed by the American Osteopathic Association that is analogous to the ACGME.
Q. Their physicians as well are also eligible to do the same thing as the allopathic physicians, correct?
A. In general, yes. They do have their own boards. So an osteopath who graduates from an osteopathic school and completes an osteopathic residency may not sit for an ABMS board. But they can sit for the osteopathic boards.
Q. And vice versa, I suppose?
A. Correct. The allopaths cannot take the osteopath boards unless they've had one year of training in an osteopathic hospital.
Q. Sounds like the two sides don't like each other.
MR. MARTIN: Object to form.
MR. CARLSON: Is that a question?
MR. LYONS: No. It's a comment only.

Page 265

Exhibit 18.
(WHEREUPON, a certain document was marked Leach Deposition Exhibit No. 18, for identification, as of 04-20-2007.)
BY MR. LYONS:
Q. This is an AMA article. Have you ever seen it?
A. I don't believe I have. I know one of the authors, Carlos Pellegrini.
Q. Would this be a peer-reviewed article?
A. This looks like it comes from the archives of surgery, which is a peer-reviewed journal.
Q. Okay. This is the only document. This will be a short one.
Just take a quick look to yourself at that first paragraph.
A. Okay.
Q. He refers to junior residents as apprentice surgeons.
Do you see that in the second sentence?
A. I do.
Q. Is that an accurate description of a

Page 266

junior resident?
MR. MARTIN: Objection. Form.
BY MR. LYONS:
Q. You can answer.
A. It's not clear what he means by a junior resident. He's referring to an earlier time. Halsted was the Chair of Surgery at Hopkins and developed a system for surgical education.
And in those times this may have been true. I think, now, surgical training is five years. I don't know what the reference to, "junior," means. I think it's much broader than being an apprentice.
So, no, I guess I don't agree with this statement as applying it currently. I agree with it as a historical reference.
Q. "Halstedian," is, what? Early 1900s?
A. Yes.
Q. Okay. Now, your view is that, "apprentice," is too narrow of a term for --
A. Yes.
Q. -- residents?
A. Correct.
Q. It would include the concept of

Page 267

apprenticeship, but it's broader?
MR. MARTIN: Well, objection to form.
BY MR. LYONS:
Q. You can answer.
A. Correct.
Q. Turn over to page 126, which is, I think, 234 on this thing.
A. Okay.
Q. Right there it says -- right there -- right before the, "Conclusions" -- it says, "What About Education?"
A. Yes.
Q. Just read the first three or four sentences of that, please.
A. Okay.
Q. Okay. That quote there is from a 2003 article, I believe, The American Journal of Surgery?
A. I think the -- quote one -- yes, the "American Journal of Surgery, 2003," correct.
Q. And the quote says -- and I quote -- "The hallmark of this experience" -- which is a graduate surgical education in the United States -- "is a commitment to patient care without regard to time, day of the week, hours worked, or on-call schedule.

Page 268

It is the patient's welfare that comes first," close quote.
Do you agree with that statement?
A. Yes. And, now, I think it takes some clarification on patient care.
I care for my wife 24 hours a day. I'm not with her right now, but I'm still caring for her. And I think that that spirit is the same in this quote -- that thinking about, caring about, the patient has no boundaries. It does not mean that you're sitting next to the patient for 24 hours.
Q. But it would include the concept of delivering some form of patient care as well as caring for the patient?
MR. MARTIN: Objection. Form.
BY THE WITNESS:
A. It would include some direct patient contact, as well as caring for the patient.
BY MR. LYONS:
Q. Okay.
A. You may or may not be interested in knowing that Halsted, who was a brilliant surgeon at Hopkins, was, also, a cocaine addict. And some people feel his work ethic was helped by some

Page 269

stimulants that others did not take.
So we've all been living in a cocaine-free world ever since trying to live up to his standards. Osler treated him. That's not part of this deposition.
Q. Okay. At any rate that statement that we just looked at would be equally applicable to the years '97 through 2002?
A. Yes. In the spirit in which I've interpreted it?
Q. Yes.
A. Yes.
Q. Now, in a document that has been filed by Mr. Martin with the Court, he has listed -- among other people -- yourself as a person who will be giving opinion testimony in this case.
First of all, are you aware of that?
A. Yes. I've received a subpoena. And I think I'm listed as an expert.
MR. CARLSON: May I make a statement?
MR. LYONS: Sure.
MR. CARLSON: I received, from one of your colleagues, a copy of a document which he referred.
And after it was filed, I have drawn

Page 270

Dr. Leach's attention to it. And that's how his attention was brought to it.
BY MR. LYONS:
Q. At any rate, the document states that you will be called. It doesn't say, "expert."
It just says, "You will be called to give testimony under certain sections of the rules of evidence."
And my sense is, from what your counsel is telling me here today, that you would have seen that document?
A. I have not seen it.
Q. Oh, you have not seen it?
A. I have not seen it. Mr. Carlson informed me --
MR. CARLSON: I drew his attention to it.
BY MR. LYONS:
Q. Okay. But you haven't had a chance to read it?
A. It wasn't given to me to read.
Q. Okay.
A. So I haven't seen the document.
Q. Oh, I see. Your counsel just told you --
A. Right.

Page 271

Q. -- that there is this document, which you've never seen?
A. Right.
MR. MARTIN: And I think I've said, in that document, that University Hospital has not retained Dr. Leach as an expert in this case.
MR. LYONS: That's not my question.
BY MR. LYONS:
Q. So you're aware that you have been listed as a witness who will give opinion testimony, but you've just never seen that document?
A. I have not seen the document.
MR. MARTIN: First of all, I don't think I say that in that disclosure, Steve.
I'm looking at it right here. Maybe I'm missing it.
MR. LYONS: Let's go back to the very beginning.
MR. MARTIN: I'll read it to you.
MR. LYONS: Let's just keep all of this off the record for the time being.
(WHEREUPON, a recess was had.)
BY MR. LYONS:
Q. While we were off the record, we have

Page 272

established that Mr. Martin has listed you as a person who will give testimony under Sections 702, 4, and 5 of the Rules of Evidence.
And he's listed you as someone who may testify -- not, "will" -- may testify, under those provisions, and -- I'm sorry -- you may give opinion testimony under those provisions.
And my understanding, Dr. Leach, is that, at this point in time, you've never read that document?
A. That's correct.
Q. You've been informed of its existence?
A. Correct.
Q. Okay. As we sit here today, have you formed any opinions that you might be giving in regard to that disclosure to us?
MR. MARTIN: Other than the ones he's already given today?
BY THE WITNESS:
A. Help me understand --
MR. CARLSON: Let me see if I can. Let me make another statement.
He's formed no opinions in preparation for this case or this testimony.

Page 273

MR. LYONS: Okay.
MR. CARLSON: Any opinions he may have articulated today, he held before he received any subpoena.
And he may or may not have testified to them today -- or about them, or in an opinion-like manner, depending on what the court says, today. I hope that's helpful.
MR. LYONS: Okay.
BY MR. LYONS:
Q. Maybe this would be a way to clear it up.
I'm sensing that, from what you're saying here, you've had no discussions with any lawyers in this case about what opinions you might give at a trial in this case; is that fair?
A. I've had discussions with both counsels, and my own, about just the basic phenomenon that I would be deposed.
And I don't know what words you used, because, "opinion," means something special for you. And from my point of view, as a nonlawyer physician, I have been deeply interested in and committed to Graduate Medical Education.
I have thought, as my organization has,

Page 274

of residents as students. And I wanted to bring clarity to the case.
And by design I was not interested in receiving compensation for that or in framing my remarks to serve either side of the case. I just wanted to get the truth out as I saw it based on my experience.
Q. Okay. But to go back to my question for a moment, you've had -- and let me just limit this to things that you might say at trial as opposed to depositions.
You've had no discussions with any lawyers in this case about what your opinions might be at trial?
A. No.
Q. Okay. And the view that you hold that residents are students -- you would agree, would you not -- that there is some disagreement with that view?
MR. MARTIN: Object to form.
BY MR. LYONS:
Q. NLRV, for example.
A. There's disagreement with NLRV in, itself. In 1979 it ruled they were students. And

Page 275

in 1999 it ruled they were both students and employees.
Q. The most recent one, in the legal system, counts the most, though; doesn't it?
MR. MARTIN: Objection. You're asking him to make a call, now, on precedential value.
MR. LYONS: But, anyhow --
MR. MARTIN: Please, let's move forward on this depo. Let's not ask him legal questions.
BY MR. LYONS:
Q. My only point to you, Doctor, is this. You have a view -- and you say the ACGME has a view -- that medical residents are students?
A. Correct.
Q. That view is not shared by everyone; is that correct?
A. I assume that to be true.
Q. Okay. Earlier this morning -- it seems like a long time ago -- you talked about the Dreyfus Model?
A. Dreyfus, yes.
Q. "Dreyfus"?
A. Yes, D-r-e-y-f-u-s.
Q. Okay. And this is a model that the ACGME

Page 276

has adopted?
A. Not in a formal way. It's a very useful model that we use and program directors use in thinking about the continuum of education.
Q. Okay. There are other models out there that deal with the same subject, correct?
A. Correct.
Q. Were those other models considered?
A. They all are, and they continue to be considered. They're useful constructs to understand the phenomena of acquisition of skills.
Q. What are some of the other models that -- is it you've used them, or you've considered using them and you've disposed of them?
A. No. No. We use them, and we use them in our thinking. We just haven't had -- the Board of Directors has not had a formal vote to accept the Dreyfus Model or not.
Q. Okay.
A. But we use them all of the time.
Q. Okay.
A. Another model might be Millers where you know, and know how, and you show, which is a continuum of experience.

Page 277

But we have actually found the Dreyfus Model more gets at the nubbin of physician education in a way that the others don't. We don't reject the others. We just find this particularly useful.
Q. Okay. Now, when a resident finishes his training, he receives a certificate of completion, assuming that he successfully completes it?
A. Not necessarily. Most programs do that. It's done at the program level.
What is required is a letter to the certifying board in which the program director attests that the resident is competent, and meets professional standards, and should be eligible for the exam.
Q. So some of them don't even receive a certificate of completion?
A. Correct.
Q. They don't receive any kind of formal medical degree like -- I mean, a degree like you would from medical school?
MR. MARTIN: Objection. Form. Are you talking University Hospital or someplace else?
MR. LYONS: I'm talking about generally first.
BY THE WITNESS:

Page 278

A. As I said, many programs give a certificate.
BY MR. LYONS:
Q. Yes.
A. And residents have this on their wall subsequently. What is required by ACGME is this letter to the boards.
MR. LYONS: Okay. Let me just take a quick moment, and talk with my colleagues, and see if we're done.
(WHEREUPON, a recess was had.)
BY MR. LYONS:
Q. Just a couple of follow-up questions.
Right there at the very end, before we broke, you had mentioned that it was both yours and the ACGME's view that medical residents were students. Do you recall that?
A. Yes.
Q. Okay. And that view is expressed based solely from the perspective of the ACGME; is that correct?
A. Yes.
Q. You don't mean to make any judgment from a tax perspective; is that correct?

Page 279

A. No, none.
Q. Okay. You also mentioned Mr. -- is it -- Dreyfus?
A. Dreyfus, yes.
Q. Who is Mr. Dreyfus?
A. Hubert Dreyfus is a professor of philosophy at the University of California, Berkeley.
Q. He is or was?
A. "Is." He is in his 80s. He spoke at one of our conferences last September. He's this tall, (indicating), wears cardigan sweaters. He couldn't be anything but a philosopher. And he's a wonderful teacher.
He has a brother, Stuart, also, at U.C. Berkeley in the mathematics department. And the two of them have written a book called, "On the Internet," in which this continuum of education is outlined in Chapter 3.
Q. Okay. Now, is the model that you spoke of -- is this what you might call an economic model, or is it just a, quote, "model"?
A. No. It's not an economic model. It's a theoretical construct about how skills are acquired.

Page 280

Q. Okay.
A. And he's used the model for how you learn how to drive a car, fly an airplane, play chess, learn a foreign language.
And we have stolen that model from him and applied it to medicine with his consent and blessing; hence, he came to speak to our group.
Q. And Mr. Miller -- he is in the same situation?
A. Yes.
Q. I assume it's Mr. Miller.
A. Yes. I don't know if he's alive, and I don't know where he is. But that's correct.
Q. He --
A. It's called, "Millers Pyramid." If you're doing a search on it, look up, "Millers Pyramid." And it will reference you to the work.
Q. This, once again, is the acquired skills theory?
A. Correct. Correct.
Q. We had talked earlier about conversations that you and I had and conversations that you and Mr. Martin had, I suppose, in the presence of Mr. Carlson.

Page 281

How many conversations did you have with Mr. Martin; do you recall?
A. I had lunch with Mr. Martin once; and then I had a subsequent conversation about a month ago. I've had one conversation with you over the phone.
Q. That lasted about 20 minutes, right?
A. Right.
MR. CARLSON: Well, actually, it was about 45. I had my watch on.
MR. LYONS: That's what you billed him, right? We're going to get him in trouble.
BY THE WITNESS:
A. He cares for me 24 hours a day.
BY MR. LYONS:
Q. I assume that your luncheon engagement with Mr. Martin was here in town?
A. It was.
Q. Do you recall about how long that discussion lasted?
A. An hour to an hour-and-a-half, I would say.
Q. And then the second conversation was on the phone?

Page 282

A. No. He was here. And it lasted, maybe, two to three hours, something like that.
Q. And that was when?
A. About a month ago.
Q. And then the luncheon was before that?
A. Correct.
Q. Okay. During the course of all of those discussions, did you ever talk about the possibility that you might be giving these opinions in court?
A. See. I don't know what you mean by, "opinions."
Q. Okay.
A. When I talked with you, the first words out of your mouth were, "Tell me why you think residents are students," or something like that.
And I told you because they are, and because they're national standards, and because of our requirements, and so on, and so on. If that meant that we were having a conversation about me giving an opinion, then the answer would be, yes.
Nobody has asked me to come to trial. I was subpoenaed to give this deposition. And I assume the testimony will appear before the Court.
Q. Okay.

Page 283

A. So I'm a little confused about opinion versus sort of expressing my lay of -- not, "lay opinion" -- but my opinion as the head of the ACGME on the topic versus expressing a formal opinion as an expert in court. I don't understand the distinction between those two.
Q. I'll leave it at that.
During this, what, four-and-a-half or five hours of conversation with Mr. Martin, over these two meetings -- was that about five hours, four-and-a-half?
A. Probably, an hour-and-a-half and two to three hours. So I would say three-and-a-half to four-and-a-half hours, something like that.
Q. Was there ever any discussion, during the course of those two conversations, about Mr. Gentile and his testimony?
A. Never. I have not seen Mr. Gentile's testimony.
The reference was made that he was one of the witnesses in the case; and that he described me as a giant in the field, which I thought was a little hyperbole.
Q. That was Mr. Martin's suggestion?

Page 284

A. Is that right?
Q. That's where the first idea came from. But, anyhow, I digressed.
But you've never seen his testimony?
A. No.
Q. Did you talk about it with Mr. Martin in your discussions?
A. No, not other than what I said.
Q. How about Mr. Nicholson? The same thing?
A. I didn't know, until you've just now mentioned it. And I assume this is Dan Nicholson?
Q. No.
A. So I don't even know.
Q. You don't even know. Obviously, that was not discussed.
A. There is a Dan Nicholson you might want to talk to.
Q. Thanks for the hint.
All right. Now, I think in one of the duties that you have as Executive Director is, you go and you talk to residents, at least, from time to time, if not a lot; is that right?
A. Correct.
Q. Okay. I take it that in these -- what

Page 285

are they -- speeches, discussion groups?
A. Just to be clear, they are not site visits. I'm not making accreditation site visits when I go into a place.
I'm there to do two things -- to listen deeply to what the residents, what the faculty, what the DIO, what the people that are in the program want to tell me; and then I usually will give a speech of some sort updating them on the ACGME's opinion about this or that -- where we are with competencies, where we are with duty hours, and so on.
Q. Okay. So you do have discussions with residents, from time to time, at these sites -- not "sites" -- at the times in which you go to these places?
A. Correct. Correct.
Q. Do you ever have any of these residents tell you that they're students?
A. Well, they know that they're students. They're in there to become a completely trained physician.
Q. Do they ever tell you that, that they're students?

Page 286

A. Yes.
Q. Use that very word?
A. Yes.
Q. Okay. Now, when a medical student graduates -- gets his M.D. -- he's called a doctor, right?
A. Correct.
Q. Okay. When he steps into the hospital to begin his residency, he's called a doctor, right?
A. Correct.
Q. Okay. The patients call him, "Dr."?
A. Yes.
Q. Okay. The attendings call him, "Dr."?
A. Yes.
Q. The little nametags on his lab coat says, "Dr.," right?
A. It does.
Q. The name on the lab coat of the medical student says, "Medical Student," right?
A. Technically, the name on the resident's says, "Dr. So and So, Resident."
Q. Yeah.
A. Whereas, the medical student has the name and, "Medical Student."

Page 287

Q. Okay. Now, when does that doctor become a physician?
A. They become a competent physician able to practice independently at the end of the ACGME residency program and upon graduation from that.
Q. Before then they're just a physician, not a competent physician?
A. Correct.
Q. Okay. One follow-up question. Who is Dan Nicholson?
A. Dan Nicholson is the -- he's sort of a lobbyist almost for the Cleveland Clinic. He lives in Washington.
But if you call him, he picks up his phone and says, "Cleveland Clinic." He is sort of a national resource for, particularly, the financing of Graduate Medical Education. But he pays attention to all of the laws as they're being developed.
And he doesn't really lobby to try and persuade the law to be different. But he informs the Cleveland Clinic of a variety of legislative events -- some that deal with education and some that don't -- that he feels would impact the

Page 288

functioning of the Cleveland Clinic.
He speaks at many of the groups like OMNI and the Association of Hospital Medical Educators. So that's what he was. I've been out of that loop for ten years. So I don't know what he's doing now. He may well be retired. That's who Dan Nicholson is.
MR. LYONS: I don't have anything further right now.
FURTHER EXAMINATION
BY MR. MARTIN:
Q. When do they become -- you were just asked a series of questions about timing.
When do physicians become licensed physicians?
A. It varies from state to state. They can apply for license as soon as -- in some states, after one year -- after completing one year of training in an ACGME residency and after having the other things -- these national boarded medical examiners' exams, and the graduating from medical school, and so on.
Now, if they do that, then they're licensed. Others require two years and, in some

Page 289

cases, three years. And for international graduates, in most cases, three years. They needn't apply -- it is, in fact, one of the things the program director will do will be to sort of pay attention to that, because it's not unheard of to graduate from residency and not have a license. And so then you have to scramble to get a license. And it takes some time to do that.

So it's variable. But they have to have a license to practice independently. So they must have a license after they graduate from residency. They frequently do. But they don't have to have a license to practice during residency.

Q. You were asked some questions about what are people called in terms of about being called, "Dr."

Do you recall what the word doctor means from Latin?

A. DocEre, which is to teach.

Q. Switching subjects -- thank you.

Switching subject for a second, do you -- let's talk about -- there were a lot of questions hours ago about the number of site visits. And there were also some questions about how large of a

Page 290

staff that you have.

A. Yes.

Q. Do you have an adequate-sized staff to do the site visits that are necessary for the accreditation process?

A. Yes.

Q. How do you do that? Do you use volunteers?

A. No. These are paid employees. We train them. We have 35 dedicated site visitors. Probably, three-quarters of them are physicians and one-quarter are Ph.D.s.

And we put them through an extensive training program. And then they -- analogous to a residency, they, then, go out on site visits with experienced site visitors, and observe, and eventually do a site visit on their own, and write their own report -- which is critiqued by the experienced site visitor.

And then we consider them able to go out on their own.

Q. Switching subjects -- this is just a series of follow-up questions. So it's going to skip around. I apologize for that.

Page 291

You were asked some questions by Mr. Lyons about the evolution over time -- about the robustness of GME programs?

A. Right.

Q. Over the last 40 years, has Graduate Medical Education become more robust or less robust in terms of the educational component?

A. More robust. There are more requirements. They are more detailed. They focus on competencies and assessments.

The evaluation tools for residents, now, typically include a 360-degree evaluation of where nurses, and patients, and medical students, and peer residents contribute to the evaluation -- as well as the attending -- focus direct observation of resident skills where somebody who knows what they're doing directly observes the resident -- while they examine the heart or do whatever they're doing -- portfolios where the experiences residents have are tracked, as well as annual -- and sometimes more frequent -- cognitive exams, including oral exams.

So all of those evaluation mechanisms have evolved over the last forty years. Forty years

Page 292

ago it was whatever your attending thought of you. They said, "Good to go," or, "not," and you would get some cognitive test. But these other things you would not have.

And then, while it's not universal, increasingly simulation is being used to evaluate residents in a more formal way. So I would say it's more robust.

Q. I'm going to switch topics, again, because these are just follow-up questions. There were some questions about the cost that teaching hospitals incur in teaching residents.

As you're sitting here today, are you prepared to testify about whether or not teaching hospitals make money or lose money on the teaching of residents or what the costs are today for those programs?

A. I think it's a wash. I mean, I'm not -- you'd have to ask the finance people. But when I was a DIO and looking after 800 residents, the direct reimbursements that our system got pretty much covered the stipend and direct costs -- like having a library and so on.

The indirect costs covered the added

Page 293

expense of being in an urban hospital with a lot of technology, and so on, because this was a large inner city teaching hospital.

So I think, if all of the residents went away, and the library went away, and all of those direct educational expenses, and the direct reimbursements went away, you would still have indigent patients, high technology, and so on.

So I think it is, no. I don't think anybody makes money with the educational reimbursement system.

And, in fact, our requirements every year require that institutions do more and more to protect the educational programs. And every year reimbursement goes down and down. And they still do it, because they're committed to the educational mission. They don't do it to make money.

Q. There were a lot of questions about one of the missions or functions of Graduate Medical Education as improving patient care.

And can you explain what the relationship is between educating residents and improving patient care and whether or not there is a time lag on there or not?

Page 294

A. All right. Well, it's a reciprocal relationship. So, first, I think you need good patient care to have good education.

But I also think good education does improve patient care. And it does it in several ways.

One -- with the longest sort of time lag -- is that it prepares a mature workforce of physicians completely trained who will be better doctors for the next 30 or 40 years. That improves patient care.

On a shorter time frame, I think that, whenever you have bright learners around asking questions about, "Why are we doing this, what does this mean," and you have faculty who have to teach them in a formal way, you end up having more conversations about the particular patient and patients in general.

And so, if I'm the only doctor in a Community Hospital, and I see you, and I have an opinion about you, and I do something, that's patient care. If I now have go back and, under critical review, defend my thoughts and my plan to others who are experts in the field, it will

Page 295

enhance. It has the potential and frequently does enhance the quality of care.

Because in preparing for that critical review, I've made my thinking a little more crisp. And in having my observations stand up -- under scrutiny of others -- in an open educational program, the product is better than it would be just on my own.

MR. MARTIN: That's all.

MR. LYONS: I've just got a couple of really quick follow-ups.

FURTHER EXAMINATION

BY MR. LYONS:

Q. You indicated that a resident may go through an entire residency without actually being licensed, correct?

A. Correct.

Q. Okay. But he must get some kind of provisional license, right?

A. Yes. And it varies from state to state. Sometimes there's an institutional license, and other times there are provisional license constraints -- or a restricted license as a trainee.

Q. But every resident has to have some form

Page 296

of a licensure?

A. Well, they may be covered under an institutional license.

Q. Okay. But they would be licensed under that institution's license?

A. Under the institutional, right. It requires no action on their part. And the State doesn't necessarily review the individual credentials. It's an institutional license.

Q. And in other instances, they actually get a provisional license from the State?

A. Correct. Right.

Q. Okay. In talking about this idea that maybe medical residency programs break even, you're not suggesting to us here that you're an economist or a finance guy, right?

A. I'm not.

Q. Okay. You don't have any expertise along those lines?

A. No.

Q. Okay. Would it be fair to say that your statement that they break even was a guess?

A. I think it's more than a guess, because for 13 years I was the designated institutional

Page 297

official at the Henry Ford Health System, which had several residency programs and about 800 residents.
And so I've seen it in my conversations. I would go to the Board of Trustees, and so on, asking for resources. And we would talk about economic things. And the Chief Financial Officer of the system explained to me a little bit about the reimbursement system.
So it's more than a guess; but I'm not holding myself up as any kind of expert.
Q. Okay. In your discussion here just a moment ago with Mr. Martin, you mentioned a reimbursement of direct expenses; do you recall that?
A. Yes.
Q. Okay. There are other reimbursements for Graduate Medical Education other than direct expenses, correct?
A. Again, my understanding is naive. But I think there are indirect medical education reimbursements designed to cover the added cost of being a complex teaching hospital.
Q. Medicaid?
A. I think, in some states, Medicaid pays

Page 298

something. There are some states where I think it doesn't. And there's some states where it doesn't pay very much.
I think children's hospitals are vulnerable. There are some HMOs that pay some token amount. But, in general, they don't. And most third-party insurance companies don't pay at all.
Again, the ACGME standards require that there be adequate resources available. And we don't care about the source of the revenue. That's up to the hospital to work out. We just make sure it's there.
Q. The hospital has to make sure the financial resources are there?
A. Correct.
Q. At the very last part of your discussion here with Mr. Martin, you had mentioned that the patient care and the learning experience go hand in hand?
A. Yes.
Q. Okay. Would it be fair to say that the patient care and the learning experience are not incident to one another, but they're all just part and parcel of the same package?

Page 299

A. I think that, in my comments to Mr. Martin, I reference the benefit of having critical conversations about a patient. And I think that's true. And I think it does enhance patient care to do that.
I think there are many ways of learning. And they're not just one thing, because you also need didactic sessions.
You need, in my opinion, simulated encounters. You need a lot of other things besides direct contact with patients, although direct contact with patients is essential.
Q. And let me just follow up with that. I guess, I thought that was my question; but maybe it didn't turn out that way.
But, anyhow, because the interdependence of the patient care, the learning experience, neither one is incident to the other; would you agree?
MR. MARTIN: Object to form.
BY THE WITNESS:
A. What is, "incident"?
BY MR. LYONS:
Q. One of them would dominate over the other

Page 300

one? They're both linked together.
A. They're linked together.
Q. They're inseparable?
A. Well, it's not uncommon, in teaching hospitals, to have wards that are so-called nonteaching wards where there's no connection with the formal educational program. Patients are just cared for there.
Q. I'm just talking about the GME situation.
A. Right.
MR. CARLSON: He was about to go into the other wards.
BY THE WITNESS:
A. So, in the other wards, they are linked, yes. Absolutely.
BY MR. LYONS:
Q. Let me see if I -- in the GME experience that we're talking about here in this case, the patient care and the learning seem to be inseparable.
For example, you can't have the learning without the patient care; is that right?
A. That's correct.
Q. Okay. So in that sense, they're

inseparable?
A. Correct. I think learning is more than patient care. But they're inseparable.
Q. Okay. So, from that standpoint, because they are inseparable, you couldn't say that one was incident to the other?
MR. MARTIN: Object to form.
BY MR. LYONS:
Q. You can answer.
A. From our point of view, when we look at a program, we look through the lens of educators. And one is -- I mean, everything is contingent on high quality patient care.
But you can have high quality patient care and a crappy educational program. You cannot have bad patient care and a good educational program.
MR. LYONS: Okay. That's it. I'm done. We're done. Thank you.
THE WITNESS: Thank you very much.
THE REPORTER: Signature?
MR. CARLSON: No waiver. We'll read it. But we'll turn it around expeditiously.
FURTHER DEPONENT SAITH NOT.

IN THE UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION
UNITED STATES OF AMERICA,)
Plaintiff,)
vs.) No. 1:05-CV-445
UNIVERSITY HOSPITAL, INC.)
Defendant.)

I hereby certify that I have read the foregoing transcript of my deposition given at the time and place aforesaid, consisting of Pages 1 to 301, inclusive, and I do again subscribe and make oath that the same is a true, correct and complete transcript of my deposition so given as aforesaid, and includes changes, if any, so made by me.

DAVID C. LEACH, M.D.
SUBSCRIBED AND SWORN TO before me this day of , A.D. 2007.

Notary Public

STATE OF ILLINOIS)
) SS:
COUNTY OF COOK)
I, JENNIFER L. BERNIER, a Notary Public within and for the County of Cook State of Illinois, and a Certified Shorthand Reporter of said state, do hereby certify:
That previous to the commencement of the examination of the witness, the witness was duly sworn to testify the whole truth concerning the matters herein;
That the foregoing deposition transcript was reported stenographically by me, was thereafter reduced to typewriting under my personal direction and constitutes a true record of the testimony given and the proceedings had;
That the said deposition was taken before me at the time and place specified;
That I am not a relative or employee or attorney or counsel, nor a relative or employee of such attorney or counsel for any of the parties hereto, nor interested directly or indirectly in the outcome of this action.
IN WITNESS WHEREOF, I do hereunto set

my hand and affix my seal of office at Chicago, Illinois, this 24th day of April, 2007.

Notary Public, Cook County,
Illinois.
My commission expires June 17, 2008

C.S.R. Certificate No. 84-4190